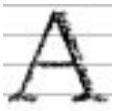
Deciding to Forego Life-Sustaining Treatment

Appendices

The Commission's Process



This Report on the ethical, legal, and practical aspects of decisions to forego life-sustaining treatment draws on work done by the Commission in several areas over the past three years, along with testimony and public comment on the subject at several public hearings and meetings. The conclusions of the Commission's reports on *Making Health Care Decisions* and on *Securing Access to Health Care,* in addition to considerations highlighted in the Commission's report *Defining Death,* were considered and applied to this Report. The topic of deciding about life-sustaining treatment was before the Commission at 12 meetings, and testimony and documentary materials were presented by physicians, nurses, social workers, patients and family members, philosophers, theologians, and lawyers by invitation and as witnesses during the public comment periods. The Commission's work was greatly assisted by many letters of advice and critiques of drafts from concerned professionals and members of the public. Especially detailed and helpful critiques of each draft were provided by Dr. Ake Grenvik, of the University of Pittsburgh, and Dr. Ronald Cranford, of the Hennepin County Medical Center in Minneapolis.

Former Commissioners

These members served on the Commission while this study was being conducted; their terms of service, which were completed before the Report was approved, are indicated in parentheses.

Renee C. Fox (July 1979--Feb. 1982)

Mario Garcia-Palmieri (July 1979-Aug. 1982)

Frances K. Graham (May 1980-Jan. 1982)

Albert R. Jonsen (July 1979-Aug. 1982)

Patricia A. King (July 1979-May 1980)

Mathilde Krim (July 1979-Oct. 1981)

Donald N. Medearis (July 1979-Feb. 1982)

Anne A. Scitovsky (July 1979-Aug. 1982)

Carolyn A. Williams (Sept. 1980-Aug. 1982)

Commission Hearings

April 9, 1981

On April 9, 1981, the Commission held a hearing in Miami, Florida, with the Chairman presiding. A major focus of the session was the case of Abe (Al) Perlmutter, a 71-year-old Floridian who was striken with amyotrophic lateral sclerosis (Lou Gehrig's Disease), a progressive neurologic disease that causes muscle deterioration, eventuating in death. Perlmutter was last hospitalized in May of 1978 when he needed an artificial respirator to support his breathing. When his attending physician declined to follow his wish that the respirator be disconnected, Perlmutter began a legal action, which eventually stretched out over two years. He died five months after the initial court proceeding, 41 hours after his respirator was removed pursuant to an order of the Florida Court of Appeals; the courts continued to rule on the legal issues even after Perlmutter had died.

The first witness before the Commission was David Hoines, the attorney who represented Perlmutter before the trial, appellate, and Florida Supreme Courts. Hoines explained that he had advised the Perlmutter family that they and the hospital staff could possibly be prosecuted for a second-degree felony under a Florida statute against "assisting self-murder" if they disconnected Al Perlmutter's respirator. In answer to questions, he stated that there were no Florida cases of which he knew in which family members or others had been prosecuted under comparable circumstances. (This conclusion was confirmed by the other attorneys who testified before the Commission during this hearing on the *Perlmutter* case.) Hoines stressed that Perlmutter did not seek to die, but preferred death to continuing to live in his debilitated condition, and that he was steadfast in this wish.

Dr. Marshall J. Brumer, a pulmonary specialist and one of Perlmutter's attending physicians, testified that he resisted the patient's decision to forego treatment because he believes that physicians have a duty to preserve life. He also believed that Perlmutter was depressed due to the death of his wife shortly after he was admitted to the hospital; his mood and outlook vacillated, and at times Perlmutter spoke of his hope for

improvement. Dr. Brumer told the Commission that in all his years of practice he had never had a patient who held to his or her wish to cease treatment consistently enough to convince Dr. Brumer. He stressed that Perlmutter had always been free to sign out of the hospital "against medical advice" (and that the doctor would have helped make provision for respirator care at home). In his experience sick and depressed patients often expressed wishes to die, but he had never encountered a patient whose wish was steadfast or whose interests would be served by physician compliance. Dr. Brumer also explained the effects that the threat of legal liability had on his decisions.

Judge John G. Ferris, trial judge of Broward County, Florida, told the Commission of his decisionmaking process, which upheld Perlmutter's right to refuse treatment. Judge Ferris said his opinion did not *order* Dr. Brumer to remove the respirator, but rather gave Perlmutter the *option* to have the respirator removed, based on his constitutional right of privacy.

Charles Musgrove, who handled the appeal for the state, noted that the law in Florida was unclear, given the dearth of case law and the silence of the legislature. He maintained the need for further clarification of patients' rights in regard to decisions to forego life-sustaining therapy. Judge Patti Englander, who had been with the State Attorney's office in Broward County during the Perlmutter litigation, explained that this was the reason for continuing the appeal after Perlmutter died. She testified further that she had urged the Florida Supreme Court (successfully) to interpret the constitutional right to privacy narrowly: it should be applied only to those, like AlPerlmutter, who, as competent, terminally ill adults, desire removal of extraordinary therapy and who have only adult children who agree with the decision.

The Commission then turned to a discussion of autonomy and institutional options in the context of terminally ill patients. Testimonv was heard from Reverend Ronal Mudd, a hospital chaplain who has counseled dying patients for '16 years and who is one of the founders of the Methodist Hospice in Jacksonville, Florida. Rev. Mudd had recently been diagnosed as having cancer and noted that research shows that doctors, nurses, and clergy tend to spend less time with patients they know to be dying than with other patients. He suggested that the Commission ought to explore more fully the hospice concept of palliative and comprehensive care for the dying.

Frank Repensek, Director of the Guardianship Program for the Elderly of Dade County, spoke on decisionmaking for incompetent patients. Repensek's staff of social workers act as guardians for the elderly, a large number of whom are referred by area hospitals when patients are not in a condition to make

an informed choice about treatment. He noted that the laws of guardianship are clearer concerning property than concerning persons.

Monsignor Bryan Walsh testified as Director of the Catholic Charities, Archdiocese of Miami, on the attitude of the Church. He explained that, while rejecting "mercy killing" and suicide as universally wrong, the Church sanctions the omission of medical procedures considered to be extraordinary or "disproportionate." These views were reiterated in the Vatican Declaration on Euthanasia of June 26, 1980. Monsignor Walsh cited the recently adopted policy and procedure statement of the Jackson Memorial Hospital as an example of how such decisions are made and noted that the guidelines were designed to alleviate uncertainty on the part of hospital staff regarding its rights and duties.

Mary Narvaez, a nurse who practices in the oncology unit of the University of Miami Hospital, discussed how nurses often find themselves torn among allegiances to the patient, the family, and the doctor. She concluded that education in management of dying patients might be useful. Dr. Peter Mansell, an Associate Professor of Medical Oncology at the University of Miami Comprehensive Cancer Center, described the tendency, particularly among American doctors, to exhaust all therapies for patients who are dying of malignant diseases. He expressed doubt that broad rules, regulations, or legislation could be drafted that would apply to the wide variety of unique cases; he also warned against an automatic assumption that spouses or close family members have the patient's "best interest" at heart.

Dr. Warren Lindau, a cardiologist in private practice who is President of the Dade County Medical Society, testified that he routinely encounters problems in decisionmaking about ending life-sustaining treatment. He emphasized the difficulty of adequate communication in the face of depression and confusion, the difficulty of ascertaining the motives of family members, and the extraordinary costs of the medical interventions involved. Vynette McGlawn, administrator of the Jackson Heights Nursing Home in Miami, discussed the plight of the elderly patient, particularly the problems of finding appropriate surrogates for incompetent patients and of making good decisions regarding both life-sustaining treatment and routine medical care through some other means.

The Commission also heard testimony on the subject of legislation at the state level that would authorize a "terminally ill patient" to execute a document directing physicians to limit treatment should a patient become so debilitated as to be unable to continue to participate in decisionmaking about his or her care. A letter from Florida State Senator Paul B. Steinberg, sponsor of the "Directive of Natural Death Act,"

was read into the record. Dr. James Farr, pastor of the Synder Memorial United Methodist Church of Jacksonville, Florida, spoke in favor of legislation to guarantee the right to refuse life-prolonging treatment, based on the doctrine of informed consent and the constitutional right of privacy. He also spoke of the need to immunize physicians and families from criminal and civil liability and the need to clarify rights with regard to insurance coverage. Dr. Farr expressed some reservations about "living will" legislation, saying that it must be drafted to protect vulnerable populations, especially the aged and severely retarded.

Thomas Horkan, an attorney testifying on behalf of the Florida Catholic Conference, opposed any legislation concerning the rights of dying patients. He said that decisions to omit or withdraw extraordinary treatment are best made by patients or families in concert with physicians and clergy. Reverend Donald McKinney, board member and founder of the national organization Concern for Dying, told the Commissioners that his organization has concluded that legislation is unnecessary and perhaps even an impediment to honoring patients' wishes. As an alternative to legislation, he suggested that educational efforts be strengthened. His organization does, however, endorse the concept of the "living will." Sidney Rosoff, a New York attorney who is President of the Society for the Right to Die, told the Commissioners of the efforts of his organization to promote living will legislation, because his group believes that legislation is preferable to litigation.

Moving from the realm of legal rules, the Commission heard from Philippa Foot, Professor of Philosophy at UCLA and Senior Research Fellow at Somerville College, Oxford. To summarize her views, she provided the Commission with a "flow diagram" that listed pertinent questions in a fashion that permitted the appropriate questions to be asked of each presented case. Professor Foot stressed that these questions only help to sort out cases and do not provide any answers.

During the time set aside for public comment, the Commission heard from Dr. Walter Sackett, a pediatrician in private practice and a former Florida State Representative who had introduced the nation's first "death with dignity" bill more than a decade earlier. He encouraged the Commission to examine the full range of situations when foregoing therapy is appropriate. George Wallace-Barnhill, Chairman of the Legal/Ethical Issues Committee of the Society for Critical Care Medicine, commented on the difficulty that these decisions pose for emergency room and critical care specialists. Carol Davis, a physical therapist, encouraged the Commission to develop some substantial guidelines on who should forego life-sustaining treatment. Jackie Matuseski, a social worker and adminis-

trator of a hospice program, advocated the provision of true choices for all patients, especially for dying patients.

June 4, 1981

The Commission next took up this subject during its hearings in Boston, which were presided over by the Chairman, because a remarkable number of noteworthy cases involving the termination of life-sustaining treatment for incompetent patients have come before the Massachusetts courts. Their decisions have sparked considerable debate within the medical and legal communities over the role of courts in the treatment or nontreatment of dying patients.

Dr. Marianne Prout, Director of the Division of Oncology at Boston University Hospital, described her work with terminally ill patients, noting that fluctuations in competence are quite common. She explained that difficulties and delays in obtaining guardians for incompetent patients have led some physicians to continue life-sustaining treatment for what she feels is an unjustified period.

Leonard Glantz, Assistant Professor of Law and Medicine at Boston University School of Medicine, summarized the state of the law in Massachusetts, discussing the *Saikewicz* case, the role of the "substituted judgment" test, and the frequency with which recourse to courts must be sought. Dr. Arnold Relman, Editor of the *New England Journal of Medicine,* endorsed the social tradition of physicians and families deciding together about care for patients of diminished capacity. Professor Jonathan Brant, of the New England College of Law in Boston, countered by noting that physicians and families may have interests that conflict with those of incompetent patients. He urged court attention for decisions involving life-sustaining treatment for dependent people.

The discussion then turned to questions of how institutional policies can be framed to encourage appropriate care of terminally ill patients. Dr. Mitchell Rabkin, President of the Beth Israel Hospital in Boston, discussed his hospital's decade of experience with policies concerning "do not resuscitate" (DNR) orders. He said such orders have become generally acceptable. Dr. Albert Fine, Director of the Intensive Care Unit at Somerville Hospital in Massachusetts, compared the policy and experience of a community hospital, such as his own, with those of a tertiary-care, teaching center, such as Beth Israel. He noted the reluctance of some older physicians to write DNR orders and warned that for some ethnic groups, explicit discussion of decisions not to resuscitate is very difficult and sometimes inappropriate.

Dr. Ned Cassem, a psychiatrist who is Chairman of the Critical Care Committee at Massachusetts General Hospital in Boston, discussed the explicit patient classification scheme once used at that hospital. Under this procedure, decisions

about the extent of treatment were guided by the "class" into which a patient is placed, based on a number of interrelated medical and nonmedical criteria. David Spackman, counsel to Boston's Board of Health and Hospitals, told the Commissioners that he has frequently received calls about the legal propriety of DNR orders and also noted that it has never been necessary for Boston City Hospital to seek court review for such an order.

The Commission also heard from Paul Rogers, a lawyer and founder of Guardianship, Inc. in Amherst, Massachusetts. He discussed the option of forming corporations to provide guardianship for institutionalized patients.

The final panel of witnesses consisted of clinicians who outlined medical considerations in foregoing life-sustaining treatment. Dr. Kevin McIntyre, a cardiologist at West Roxbury V.A. Hospital in Massachusetts, said that where prognosis is very poor and the family and medical staff are in agreement, termination of life-sustaining therapy is appropriate. Gen Foley, R.N., Assistant Director of Pediatric Nursing at Memorial Sloan-Kettering Hospital in New York, discussed the potential for meaningful long-term relationships with cancer patients, especially children. Dr. Paul Hardy, a neuropsychiatrist at Paul Dever State School in Taunton, Massachusetts, used the case of Earle Spring (a demented patient in a nursing home whose wife and son wished to stop his kidney dialysis) as an example that highlights the need for accurate professional assessment to undergird a determination of incompetence. The final witness was Dr. Ruth Purtilo, Associate Professor of Health Care, Ethics, and Humanistic Studies at Massachusetts General Hospital, who urged the Commission to look beyond high-technology measures in its consideration of life-sustaining care.

September 12, 1981

In Los Angeles, California, Commissioner Mario Garcia-Palmieri presided while testimony was taken from a panel of physicians and nurses who discussed their experiences with decisions about aggressive care. The panel included Sharon Imbus, a nurse at the the Burn Center at U.S.C. Medical School in Los Angeles; Dr. Norman K. Brown, a physician from Seattle, Washington; and Gary Wolfe, Director for Ambulatory Services for Peninsula Hospital in San Pedro, California. Imbus discussed decisionmaking involving burned patients for whom survival is unprecedented, including the patient's authority to decline all life-sustaining care. Dr. Brown presented his findings regarding the accepted practice of nontreatment of fever at proprietary and charitable nursing homes in Seattle. Wolfe reported that his hospital had assessed community needs two years previously and had found a substantial perceived need for flexible and responsive care for dying

patients. As a result, the hospital established a hospice, with emphasis upon symptom control, patient autonomy, and a multidisciplinary approach to comprehensive patient and family care.

The day's second session was chaired by Commissioner Frances K. Graham; the witnesses were Steve Lipton, an attorney who had been a legislative assistant to Assemblyman Barry Keene when the Natural Death Act was passed; William Thompson, a Ph.D. candidate in psychology and a law student at Stanford University; Sister Corinne Bayley, director of bioethics teaching for a group of hospitals in California; Dr. Francis Healy, a private practitioner from Burlingame, California, who chairs the California Medical Association (CMA) Committee on Evolving Trends; and Bruce Miller, a philosopher and assistant coordinator of the medical humanities program at Michigan State University who worked on the proposed Michigan Medical Treatment Decision Act.

Mr. Lipton stated that the legislative findings section of the preamble to the Natural Death Act, affirming the principle of autonomy in the face of fatal diseases, constitutes the Act's most significant portion. Thompson reported research on the understanding and use of the Natural Death Act, which demonstrated wide variability and substantial misunderstanding of the law among physicians. Sister Bayley testified that the Natural Death Act can be important in patient care when it leads to communication between patients and care givers but that it rarely changes preexisting decision patterns. Notwithstanding the broad statement of rights in the Act's preamble, she noted that the existence of legal liabilities has encouraged a perception among physicians and nurses that they are obligated to treat every patient with every possible beneficial modality of care not excluded by a valid "directive." She believes there ought to be little obligation to provide the intervention if it offers very little prospect of recovery.

Besides reporting the results of the CMA's survey on the use of "living wills," Dr. Healy testified that he believes patients want (and physicians are comfortable with) oral and joint decisionmaking, which is made awkward by written forms and technicalities. Dr. Healy also acknowledged that he usually talks with families about patients, but the content of the discussion is different than in conversations with patients. He stated that physicians do not and should not force explicit information upon patients. Miller reported on the model legislation that was proposed in Michigan for designating in advance a proxy decisionmaker and attributed the bill's failure to the opposition of the Right to Life Council and the Michigan Catholic Conference.

Commissioner Renee C. Fox presided over the afternoon sessions. The first panel, on actions leading to death, consisted

of Leslie S. Rothenberg, an attorney, and Dr. Robert Kaiser. who are Co-Chairmen of the Joint ad hoc Committee on Biomedical Ethics of the Los Angeles County Medical Association and the Los Angles County Bar Association; Dr. Lawrence Pitts, Chief of Neurosurgery at San Francisco General Hospital; Dr. Joseph K. Indenbaum, Medical Director of the County Department of Health Services; and George Oakes, Deputy District Attorney for Los Angeles County. Rothenberg reviewed the process that led to the ad hoc committee's "Guidelines for Discontinuation of Life-Support," which apply to mechanical respirators or ventilators, and outlined the guidelines' accomplishments and shortcomings. Dr. Kaiser reported that the guidelines have had some impact on physicians and have been the subject of substantial discussion. Oakes stated that the guidelines had been helpful by making the community standard of medical practice clearer, by clarifying the legality of certain actions, and by focusing public education and discussion.

Beginning with a description of "persistent vegetative state" (PVS), based on his studies of head injury, Dr. Pitts testified that he usually provides vigorous support for all potential PVS patients for the first month; before this time, he does not believe that the data are adequate to estimate prognosis reliably. If the patient remains vegetative thereafter, Dr. Pitts initiates no new therapy.

Dr. Indenbaum reported the origin, composition, and activities of the Citizen's Committee on Life-Support Policies, which promulgated guidelines for nonresuscitation ("no-code") in county hospitals.

The day's final panel discussed affirmative steps to end life in terminal situations. The first witness, Dr. Richard Scott, who is also a lawyer, spoke as General Counsel of Hemlock, a Los Angeles-based organization that supports legalization of active, voluntary euthanasia. Dr. Scott noted that although terminally ill patients who wish to die peacefully have the right to leave hospitals and die, doing so may entail substantial suffering and practical difficulties. He also argued that the distinction between voluntary and involuntary suicide is paramount; the voluntary request of the dying person should be a defense against charges of homicide or assisting suicide. The final witness was Edwin Shneidman, Professor of Thanatology at UCLA, who talked about the difficulties in assessing rationality and voluntariness.

During the time set aside for public comment, the Commission heard from Dr. Richard J. Lesco, of Torrance, California, who suggested that any policy with respect to consent regarding treatment of incompetent, dying patients should exonerate health care providers who make a "good-faith effort" to obtain consent from a relative or friend.

October 23, 1981

During a Commission meeting that discussed common themes in the Commission's work, James M. Gustafson, Professor of Theological Ethics at the University of Chicago, presented a case study on decisions to forego treatment of an infant in a neonatal intensive care unit. An extensive discussion ensued about the moral relevance of the effects on the family and involved health care personnel of a decision not to treat an infant. The Commissioners agreed that it is sometimes appropriate to consider the effects that extending a person's life has on the quality of life of others, but that serious ethical problems can arise when such considerations play a large part in individual decisions or when the economic effects are treated differently for people dependent on public programs from those who are not.

December 12, 1981

At this meeting, the Commissioners considered the issues raised by cardiac resuscitation of hospitalized patients and by the decision against resuscitation, as set forth in a paper drafted for possible inclusion in the report. Dr. Sol Edelstein, director of the emergency room at George Washington University Hospital in Washington, D.C., served as a resource person for the discussion. It was noted that the decision to write a "no-code" or "do not resuscitate" order assumes that death would be preferable to the life the patient would experience after resuscitation; moreover, since advance deliberation is possible, institutional policies to guide decisionmaking may be ethically and legally desirable.

The Commission also discussed treatment options for permanently unconscious patients, for which neurologist David Levy of Cornell University Medical Center in New York City served as a resource expert. Dr. Levy stated that the term "permanently unconscious patient" is a useful term to encompass subcategories of unconscious patients with different etiologies. Although prognosis studies for some subcategories are just beginning, Dr. Levy and his colleagues have found that the diagnosis can be made reliably for certain types of patients. In response to questions, Dr. Levy confirmed that from what is known of the nervous system it is highly unlikely that unconscious people feel pain.

January 8-9, 1982

During the first day of this hearing, the Commission continued the previous month's discussions of decisions to resuscitate hospital patients and of the care of those who are permanently unconscious. The thrust of the draft chapters was approved, and numerous suggestions were made for revisions in specific language and for the addition of further points.

On January 9, Commissioner Fox presided over the morning's discussion of neonatal intensive care, which began

with three witnesses from the Intensive Care Nursery at Children's Hospital in Washington, D.C. (Dr. Anne Fletcher, the Director; Carole Kennon, a social worker with major responsibility for the concerns of families; and Judy Brown, a nurse practitioner) and Jeanne Guillemin, a sociologist from Boston College who had spent over a year as a participant-observer in neonatal intensive care units in the United States and six other countries.

After Dr. Fletcher presented three case vignettes to illustrate the complexities of decisionmaking in neonatal intensive care, she and her colleagues described the team techniques used at Children's Hospital with parents who must suddenly face coping with decisions about their very ill newborn. The witnesses urged that nontreatment for babies with a very poor chance of recovery or of independent function should be possible and that the choice should rest principally with the parents.

The relationships among professionals, between the community and the hospital, and among hospitals were described by Guillemin, who pointed out that the setting is very complex from a sociological viewpoint. She listed some of the numerous decision points from delivery to resolution, noting that most of the serious conflict about treatment decisions comes from the inclusion of "marginal cases" within the sphere of treatment. She observed that, in other countries, clear guidelines exist to preclude referral of marginally viable newborns. Guillemin felt strongly that emphasis by public and private agencies on developing facilities and personnel for neonatal intensive care has not been balanced by appropriate concern for prevention of neonatal problems.

A second panel on the obligation to sustain the life of the infant consisted of John Fletcher, assistant for bioethics working at the National Institutes of Health; Philip Devine, Professor of Philosophy at the University of Scranton in Pennsylvania; and Mary Anne Warren, a Professor of Philosophy at San Francisco State University. Warren initiated the discussion by conceptualizing the factors that would, in her view, justify foregoing life-sustaining treatment, such as the expected length of an infant's life, its quality, and the effects of the treatment on family members. Devine disagreed with the thrust of these remarks; he stated his belief that a newborn. must be considered to be as fully human and in the same situation as an incompetent adult who has not left prior directives. Fletcher said that medical criteria regarding outcomes should be primary and that the physician bears an obligation to present the facts with a recommendation as to the justifiable course of action; he was opposed, however, to allowing physicians to administer active euthanasia. Warren stated that in her view it is sometimes mandatory to kill in

order to prevent terrible suffering while dying. In regard to whether feeding an infant has a special moral claim, all panelists agreed that the claim to ordinary feeding is usually stronger than the claim for artificial feeding, and that there are reasons that justify foregoing artificial feeding that would not apply to ordinary feeding.

Commissioner Donald W. Medearis presided over the afternoon session, during which the elements of responsible decisionmaking about very sick newborns were discussed. The participants were Dr. Raymond Duff, a pediatrician involved principally in primary care residency training at Yale-New Haven Medical Center, who in 1973 co-authored the first systematic description of nontreatment decisions for infants; Dr. Norman Fost, a pediatrician who directs the medical ethics program at the University of Wisconsin Medical School at Madison; Dr. Peter Auld, a neonatologist who directs the neonatal intensive care unit at New York Hospital; and Dr. John Freeman, a pediatric neurologist working especially with children with spina bifida at Johns Hopkins Hoqpital.

Dr. Duff characterized the best procedures for decisions about life-sustaining therapy as those that are made in private and that rest on collaboration between family and physicians acting on their own ideologies. While recognizing that such decisions usually have some self-serving elements, Dr. Duff argued that the "pro-life" ideology misuses the homicide laws when it makes prudent and responsible decisions seem to be malicious. Dr. Fost characterized a high-quality proxy decision-maker as a dispassionate person who has the full facts and has disinterested status, and stated that parents frequently fall seriously short of this ideal. Dr. Auld pointed out that there are three major groups for whom decisionmaking problems arise: obvious nonsurvivors, patients without family members capable of participating effectively in decisions, and patients with chronically handicapping conditions compatible with a fairly long life. Dr. Freeman advocated that all babies should be intensively treated until the outcome is more clear even if this means having to (and being able to) actively kill some very handicapped survivors. Dr. Fost responded that active euthanasia could be moral and humane, but that there may be important social reasons to preclude active euthanasia. He emphasized the importance of avoiding the feeling of urgency in making decisions and the importance of a general preference to accept unwarranted suffering over unwarranted death.

In order to limit abuses of various forms of foregoing therapy, Dr. Fost recommended establishing institutional review boards on the model of those established for research. Dr. Duff agreed that procedural guidance is needed, but emphasized that such procedures should safeguard the integrity of the family.

February 13, 1982

The second day of the Commission's February meeting was devoted entirely to the issues arising from neonatal intensive care. The session was chaired by Commissioner Albert R. Jonsen, who suggested a tripartite classification scheme for seriously ill newborns: those who will die despite therapy, those for whom prolonged therapy will sustain life but not cure the affliction, and those whose life-threatening condition can be corrected but who will still have other, severe handicaps. The possibility of and justification for Jonsen's scheme and alternative ones were the subjects of the Commission's deliberations, with special emphasis on the diagnostic and prognostic uncertainties surrounding all categories. It was agreed that therapy may be foregone both in the first category and in the second category when it will be futile. The Commissioners rejected the notion that the decisions should be made according to a formula based on babies' weight, height, and so forth. The different meanings of "nonintervention" when no effective treatment exists and when medicine does possess the technical means of treatment were discussed; specific interventions were also discussed. The Commission concluded that these differences, as well as appropriate decisionmaking mechanisms, should be spelled out in the Report.

June 10-11, 1982

On the first day of this meeting, a panel of physicians focused on the potential import of the Commission's report for national health policy and clinical decisionmaking. The panelists included Dr. Ronald Cranford, a neurologist at Hennepin County Medical Center in Minneapolis, Minnesota; Dr. Mitchell Rabkin, Medical Director of the Beth Israel Hospital in Boston; and Daniel Callahan, Director of the Institute of Society, Ethics and the Life Sciences (the Hastings Center). Dr. Cranford noted the role of hospital ethics committees in facilitating communication, fostering education, and providing public accountability. While cautioning against viewing these committees as a decisionmaking panacea, Dr. Cranford noted that only a small percent of hospitals have such bodies and suggested more institutions should be encouraged to establish and evaluate them. Both Dr. Cranford and Dr. Rabkin praised the Commission's Report as advocating a good, balanced policy. Callahan urged that particular attention be paid to the costs of care for the dying and the social context into which the report would fit. The Commissioners and witnesses also discussed the changing attitudes of patients and providers toward foregoing life-sustaining therapy.

The morning's second panel, devoted to a conceptual analysis of the draft Report, included Dr. Callahan, from the first session; Joel Feinberg, Professor of Philosophy at the

University of Arizona in Tucson; and Richard A. McCormick, S.J., S.T.D., of the Kennedy Institute's Center for Bioethics in Washington, D.C. Much of their discussion centered on Chapter Two, especially its treatment of the traditional philosophical distinctions, such as acting versus refraining, intended outcomes versus merely foreseen consequences, and ordinary versus extraordinary treatment.

Feinberg termed critical the distinction between general rules and actions in individual cases and pointed out the need for legislatures to err on the safe side in seeking a balance between justified killings and unjustified prolongations of life, noting that permissibility does not always equal justifiability. Father McCormick expressed grave reservations about the discussion of the traditional distinctions, beginning with that of allowing to die versus killing. He suggested replacing the hypothetical case then included in that discussion with a series of examples more germane to the medical setting that would highlight dangers of abuse and coercion. Callahan cautioned against mixing questions of fact and value, and called the issue of what ought legitimately to be a part of a public policy statement the biggest problem for the report.

In a session devoted to comments from members of the public, Dr. James J. Smith, Director of the Nuclear Medicine Service at the Veterans Administration Central Office, speaking on his own behalf, disagreed with Father McCormick's view of the value of life for those incapable of human interaction, stating that communication might be possible even with patients in persistent vegetative state. John Paris, S.J., of the University of Massachusetts Medical School and Holy Cross College, urged that Chapter Two be revised and rewritten so that it could be of use in teaching medical students about ethical issues. Dr. Olga Fairfax, founder of United Methodists for Life, raised the recent case of Infant Doe in Indiana, calling the decision "not to treat" an Orwellian euphemism for starvation.

A panel on public policy and legal implications—Dr. Willard Gaylin, psychoanalyst and President of the Hastings Center; John Robertson, Professor at the University of Wisconsin Law School; and Robert Burt, Professor at the Yale Law School—made wide-ranging suggestions for improving the draft. Dr. Gaylin sounded a general call against lawyers' and philosophers' infatuation with hard cases and decried the popularity of framing issues in terms of "rights," with its tendency towards binary options and absolutes. He also urged a reevaluation of the Report's emphasis on the patient as an individual, in favor of a less isolated view of the patient as part of a network of family and friends. Robertson agreed with the tone of Chapters One and Two, but suggested they be more directly grounded in public policy questions. He also cautioned

that the establishment of ethics committees raises a number of legal issues, including composition, liability of members, legal effect of decisions, the source of authority, and the applicability of conspiracy and other criminal actions against ethics committee members who ratify decisions not to treat.

Burt urged increased attention to the possibility of education and training for those who deal with the dying as professionais, volunteers, or family members. Regarding incompetent patients, Burt urged a clearer identification of who is to be guardian, as well as a sharper delineation of the guardian's role, spelling out what training and capacities might be required. He suggested that the Report may encourage too ready resort to the courts, which might place too high a value on objectivity and leave no room for the moral ambiguity and anguish that should accompany decisions not to treat.

Finally, the Department of Health and Human Services' letter to hospitals warning that decisions to withhold treatment for handicapped newborns violates Federal law and could jeopardize their receipt of Federal funds sparked critical comments by both witnesses and the Commissioners.

On the second day of the June meeting the Commissioners continued deliberating on the draft Report, especially as it portrayed the standards and procedures for decisionmaking on behalf of patients who do not have the capacity to make their own health care decisions. It was also decided that the criticism of the traditional distinctions in Chapter Two should be less severe, since these distinctions are of continuing value—if the label does not merely serve to substitute for appropriate analysis—to people who must decide actual cases.

During the public comment session, Stephanie Ezrol of Lyndon Larouche's National Democratic Policy Committee read from the Nuremberg War Crimes Trial and said that legalizing "euthanasia" is tantamount to murder.

August 13, 1982

The morning session of this meeting was devoted to a discussion of the sections of the draft Report on the effect of institutional arrangements on the decisions of patients and on decisionmaking about seriously ill newborns. During the morning's public comment session Barbara T. Syska of Silver Spring, Maryland, urged more attention to the prevention of central nervous system defects in newborns.

October 8-9, 1982

The Commission considered in detail a draft of the full Report, directing the staff to make various modifications and expansions. During the session scheduled for public comment, the Commission heard from Harris Coulter, a medical historian, who pointed out the important role of third-party payors and hospitals, which in his view encourage continued treatment of patients on life-support systems because of the profit

motive. Earl Appleby, a staff member of Senator Jesse Helms (R-N.C.), speaking in his capacity as a private citizen, defended the medical profession against any venal motives in offering life-prolonging therapy, based upon the experiences he and his mother have had in caring for his comatose father at home for several years. Ronald Kokinda, representing the National Democratic Policy Committee, testified that decisions to forego life-sustaining therapy reflect a "cultural pessimism" and a giving-up on life. Dr. Dorothy Henneman, a practicing physician, encouraged the Commission to present and evaluate the philosophical issues involved in the Report.

November 12, 1982

The Commission discussed the modifications made in the draft, especially as they related to Chapter Two, and examined point-by-point the summary of conclusions in the introduction to the Report.

December 15, 1982

The Commission reviewed the changes' directed at the November meeting and adopted the Report unanimously, with directions on necessary editorial changes and completion of the references before publication.

Mr. Fred Benjamin, a Department of Transportation employee, spoke on his own behalf concerning the importance of educating people to make informed medical decisions. A letter from Dr. Joseph G. Zimring, F.A.A.F.P., on decisions to forego treatment and on the definition of death was read into the record.

Supportive Care for Dying Patients: An Introduction for Health Care Professionals

B

In few areas of health care are people's evaluations of their experiences so varied and uniquely personal as in their assessments of the nature and value of the processes associated with dying. For some, every moment of life is of inestimable value; for others, life without some desired level of mental or physical ability is worthless or burdensome. **A** moderate degree of suffering may be an important means of personal growth and religious experience to one person, but only frightening or despicable to another. Helping patients whose very definitions of what counts as health and disease are so different requires the utmost sensitivity and wisdom of health care professionals.

Dying has many common symptoms and manifestations; their medical treatment is considered in this Appendix. However, first it is important to remember that dying is not principally a "disease" calling for medical "remedies." Primarily, dying is the extinguishing of a human life, and those who provide medical care while patients are dying cannot effectively treat symptoms without caring for the patient as a person. Patients and their families will commonly be feeling great stress. The practitioner will have to be careful to accommodate the patient's priorities. Finding some meaning in death or saying farewell to family and friends may well be more important for a person than having a bowel obstruction treated or a dressing changed.

The goals for those who provide care for a dying patient include:

(1) Competent diagnosis, therapy, and prognosis. Medical skill and clinical acumen are extremely valuable as the patient's medical condition deteriorates, and compassion and respect for the patient ought never to be allowed to substitute for competent care.

(2) Symptom control to allow the patient to live as fully as possible.

(3) Advancing the patient's life goals and making available those experiences that the patient values.

(4) Personal loyalty and reliability. Trust is very important to the patient's peace of mind, and is undercut by unreliability, dishonesty, evasiveness, hubris, or abandonment by significant others.

(5) Help for family and friends during the patient's dying and during bereavement.

(6) Comprehensive attention, involving an appropriate team of care givers and an appropriate institutional or home setting. With such support, people who prefer to do so can usually die at home.

General Management

Skillful evaluation of a patient's history and physical examination and frequent review of the care plan will save dying patients more trouble than any drugs and tests could. Often, getting a definitive diagnosis of a complication would entail rehospitalization or distressing invasive procedures. However, knowledge of the natural history of a patient's diseases, the careful taking of an individual's history, and a skillful physical examination can in many cases make a presumptive diagnosis sufficiently certain to warrant the initiation of appropriate ameliorative therapy. Sometimes the diagnosis may be uncertain but all the remediable etiologies respond to fairly simple and acceptable therapies, so one or more treatment trials can be undertaken without a definitive diagnosis.

Often people who are dying have multiple organ failures, making deleterious side effects of drugs and therapies even more common than in their general application. Drugs cleared through the kidney almost invariably require reduced dosage, either in amount per dose or frequency.

The goals of medical practice should not be limited to improving a patient's health, but they must also include enhancing his or her self-respect and self-determination. For dying patients, who are in fact losing control over their lives in the most central way, control over the decisions that are still to be made is often very important. Some physicians deny this benefit through simple inattention or a rationalization that they are protecting the patient. Although patients expect tact and sympathy from their physicians, all available evidence indicates that they want to be included in decisionmaking about their care. Physicians and others who care for dying patients need to develop skills in communicating with patients and families so that most decisions about resuscitation, aggressive care, institutional arrangements, and symptom control remain the patient's.

Symptom Control

Nearly all dying patients have symptoms that can be relieved by judicious medical intervention. The symptom most feared in advance is pain, but mental function disturbances, nausea, diarrhea, constipation, infections, skin sores, and respiratory difficulty are also very distressing and often remediable as well. In this section some of the most common symptoms and approaches to controlling them are delineated.

Controlling symptoms sometimes requires relatively aggressive therapies.[1] The fact that a patient has only a few

[1] *See e.g., D.S.* Robbie, *Addendum: Nerve Blocks and Other Proce-*

weeks or months left is *relevant* to the decision to use palliative radiotherapy or diverting colostomy—but a brief prognosis should not be taken to *preclude* these aggressive treatments. Rather, the individual's situation and likely course with each of various interventions should be considered carefully by the physician, other care providers, the patient, family, and friends. Sometimes, not only aggressive treatment of current symptoms but also aggressive treatment to forestall likely future symptoms is justified. Making the decision to undertake aggressive or risky treatments will often be unavoidably difficult, since it forces decisionmakers to confront the ambiguities of prognosis and the uncertainty of therapeutic effects.

Pain. Only a minority of dying patients—fewer than half of those with malignancies, for example—have substantial problems with pain,[2] yet many people fear pain while dying more than death itself. Acute pain, as from an injury, is the healthy body's way of protecting the injured part and taking steps to repair it. On the other hand, chronic and progressive pain often serves no useful function; instead it wastes the patient's strength and resolve and destroys whatever value he or she could have found in living. Fortunately, the chronic pain of dying patients in almost always fairly easy to control.

First, the care givers should seek a remediable cause: pathologic fractures, for example, usually deserve specific intervention rather than drugs.[3] In fact, pathologic fractures can often be averted by prophylactic nailing. Radiation therapy or chemotherapy of tumors can prevent or relieve symptoms, even when cure is not possible.

Second, anxiety and fear must be mitigated. Pain is extremely subjective. A standard painful stimulus is perceived

dures, in Cicely M. Saunders, ed., THE MANAGEMENT OF TERMINAL DISEASE, Edward Arnold Publishers Ltd., London (1978) at 92; Thelma D. Bates, *Radiotherapy in Terminal Care, id.* at 119; Thelma D. Bates and Therese Vanier, *Palliation by Cytotoxic Chemotherapy and Hormone Therapy, id.* at 125; Michael R. Williams, *The Place of Surgery in Terminal Care, id.* at 134; B.A. Meyerson, *The Role of Neurosurgery in the Treatment of Cancer Pain,* 74 ACTA ANESTH. SCAND. (Supp.) 109 (1982); S. Arner, *The Role of Nerve Blocks in the Treatment of Cancer, id.* at 104; *C.* Bolund, *Pain Relief through Radiotherapy and Chemotherapy, id.* at 114. *See also,* a collection of general and specific articles in *International Symposium on Pain of Advanced Cancer,* in John J. Bonica *et al.,* eds., 2 ADVANCES IN PAIN RESEARCH AND THERAPY, Raven Press, New York (1979) (hereinafter cited as SYMPOSIUM ON PAIN); Robert G. Twycross and Vittorio Ventafridda, eds., THE CONTINUING CARE OF TERMINAL CANCER PATIENTS, Pergamon Press, New York (1980).

[2] Robert G. Twycross, *Relief of Pain,* in Saunders, *supra* not 1, at 66.

[3] *Id.* at 88-90.

as much worse if the patient is tired, afraid, isolated, or depressed.[4] Although some psychological problems warrant specific therapy (as discussed in the next section), surprisingly effective results can be obtained with a calm, competent, and reassuring approach by care givers. A nurse or physician who can say with assurance that a patient need never (or never again) feel overwhelmed by pain, and who proceeds to demonstrate the truth of the assertion, greatly eases the patient's mind and reduces his or her attentiveness to the pain. Conversely, the most potent stimulus to fear of pain, and thus to increased pain, is inadequately treated pain. Patients who obtain short periods of relief with a narcotic followed by periods of pain while waiting for a next dose become trained to fear the expected onset of pain while pain-free and to actively seek the drug constantly.[5] Such behavior commonly alienates hospital staff and leads to increased isolation. Adequate treatment for the pain can break this cycle.

Narcotics. If a patient's pain is uncontrolled, the primary aim is to control it; risking a period of sedation is not usually a contraindication to fully effective doses. For rapid and flexible control initially, intramuscular or subcutaneous[6] morphine is unsurpassed. In a patient who has not been on narcotics, 2-5 mg. parenterally (using a higher dosage with younger and heavier patients in better general condition and a lower one in frail, thin, or elderly patients or those with reduced respiratory reserve) given every 15-30 minutes with constant observation is uniformly effective. For patients who have been taking narcotics without sufficient relief, giving 1.5 to 2 times the previous dose is usually an effective alternative initial dose. Once the patient is untroubled or asleep, the care giver can judge how sensitive the patient is and how severe the pain, and a regular regimen can be started. If control was achieved with one or two low doses, non-opioid analgesics (see p. 284 *infra*) with or without codeine (30-60 mg. orally every **3-6** hours) may be sufficient. If more was needed, initial use of oral hydromorphone or morphine is probably better.

Control of pain with narcotics involves continual experimention to keep the dose in the zone between oversedation on the one hand and recurrence of pain on the other, so that the uatient stays fairly alert but pain-free. Most patients have a

[4] *Id.* at 68; *C.* Richard Chapman, *Psychologic and Behavorial Aspects of Cancer Pain,* in SYMPOSIUM ON PAIN, *supra* note 1, at **45.**

[5] Twycross, *supra* note 2, at 71-72.

[6] The effectiveness and time course of narcotics is approximately equal for intramuscular and subcutaneous adminstration. Jerome H. Jaffe and William R. Martin, *Opioid Analgesics and Antagonists,* in Alfred Goodman Gilman, Louis S. Goodman, and Alfred Gilman, eds., GOODMAN AND GILMAN'S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS, Macmillan Pub. Co., New York (6th ed. 1980) at 494.

substantial "therapeutic window," though what doses achieve it and at what frequency do change over time.' For a few patients, especially when death is close, there is no such zone and the physician, with the patient's or family's concurrence, must be willing to accept sedation if pain is to be avoided.

Oral medications are preferred to parenteral whenever course, patients demonstrate substantial variability in their oral-parenteral ratio with each drug[9] and similar variability in their individual ratio between drugs.[10] However, all narcotics are less potent orally, sometimes dramatically so[11] (see Table B1, p. 281 *infra*). Oral administration gives more constant blood and cerebrospinal fluid levels than intermittant parenteral dosing. Furthermore, parenteral administration to a dying patient so often becomes difficult as the muscle mass wastes and the superficial circulation is reduced. The patient also has more control over the oral route. Many patients find liquid preparations easier to take than tablets and capsules. A few patients benefit from the availability of narcotic suppositories[12] (morphine, hydromorphone (Dilaudid 3 mg.), or oxymorphone (Numorphan 5 mg.)) but bioavailability is variable. Yet suppositories can sometimes permit home care when a patient's family cannot administer injectable medications.

Physicians should become very familiar with a small number of narcotics, rather than using each of the numerous preparations only occasionally. Codeine for moderate pain, morphine or hydromorphone for moderate or severe pain, and methadone (Dolophine) or levorphanol (Levo-Diomoran) for fairly stable severe pain are sufficient for almost all narcotic needs. Codeine in usual doses has moderate efficacy, lasts 3-6 hours when given orally, and has few side effects except constipation and occasional nausea.

Morphine and hydromorphone are usually effective for about 3-4 hours and the dosage can be increased sufficiently to overcome almost any severe pain. At higher doses, morphine is thought to be more reliable than hydromorphone but it may cause nausea more often. However, hydromorphone is easily abused and is therefore sometimes difficult to obtain from

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[7] Twycross, *supra* note 2, at 71-72, 83-85; William T. Beaver, *Management of Cancer Pain with Parenteral Medication,* 244 J.A.M.A. 2653 (1980); L.K. Paalzow, *Pharmacokinetic Aspects of Optimal Pain Treatment,* 74 ACTA ANESTH. SCAND. (Suppl.)37 (1982).

[8] Beaver, *supra* note 7.

[9] Jaffeand Martin, *supra* note 6, at 507-09.

[10] Jack McKay Zimmerman, HOSPICE: COMPLETE CARE FOR THE TERMINALLY ILL, Urban & Schwarzenberg. Baltimore (1981)at 67.

[11] Jaffe and Martin, *supra* note 6, at 505-506; Charles E. Inturrisi, *Narcotic Drugs,* in Marcus Reidenberg, ed.. *Clinical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1061 (1982).

[12] Twycross, *supra* note 2, at 76.

Table B1:

Approximate Equianalgesic Doses of Narcotics When Used for Chronic Pain*

Drug	P.O. (mg.)	I.M. or SQ. dose (mg.)	Usual Effective Interval (hrs.)
Codeine	200†	130†	3-4 t i.m. and sq., 4-6 p.o.
Morphine	60**	10 mg.	3-4 i.m. or sq., 4-6 p.o.
Hydro-morphone	7.5	1.5	3-4 i.m. or sq., 4-6 p.o.
Methadone	20	10	longer††
Levorphanol	4	2	longer‡‡

* Doses from Raymond W. Houde. *Systemic Analgesics and Related Drugs: Narcotic Analgesics*, in John J. Bonica and Vittorio Ventafridda, eds., INTERNATIONAL SYMPOSIUM ON PAIN OF ADVANCED CANCER. 2 ADVANCES IN PAIN RESEARCH AND THERAPY, Raven Press, New York (1979) at 266; modified as noted. Intervals from personal communication with Dr. Raymond Houde (Jan. 1983), modified as noted.

t Although these are the approximate doses of codeine to equal the analgesic effect of 10 mg. parenteral morphine, patients who need more than 100 mg. codeine orally or 60 mg. parenterally usually are switched to one of the more potent drugs. The ratio of oral codeine to oral morphine for equianalgesia is quite variable, having been reported to be as much as 13:1; R.W. Houde, S.L. Wallenstein, and W.T. Beaver, *Clinical Measurement of Pain*, in G. de Steuras, ed., ANALCETICS, Academic Press, New York (1965) at 75.92.

† The effective interval for codeine is often given as 4-6 hours; *see e.g.* Alfred Goodman Gilman, Louis S. Goodman. and Alfred Gilman, eds., GOODMAN AND GILMAN'S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS. Macmillan Pub. Co.. New York (6th ed. 1980) at 507. Many clinicians are finding (and Houde has confirmed in cross-over studies) that the effective interval is actually close to that of morphine, about 3-4 hours, especially in parenteral administration; personal communication with Dr. Raymond Houde (Jan.1983).

** There is substantial uncertainty as to the correct oral-parenteral ratio for morphine. In single doses. the ratio is conventially given as 6:1 (oral: parenteral); Gilman, Goodman, and Gilman, *supra* note t, at 507; Houde, *supra* note*, at 266. However, in chronic use, the ratio seems to be lower. Robert G. Twycross, *The Brompton Cocktail*, in Bonica and Ventafridda. *supra* note*. at 291, 293. postulates a ratio with morphine solution of 3:1 (oral to parenteral). Others feel it may well be as low as 2:1 Paul D. Henteleff and Elliot Fingerote. *Clinical Study of Relative Effectiveness of Narcotics*, at the 5th Annual Meeting and 8th Symposium of the National Hospice Organization, Washington, Nov. 9, 1982. The value used here, 4:1 (oral to parenteral) was suggested by Dr. William Beaver (personal communication, Dec. 1982) as a reasonable estimate for the usual progression from oral medications to parenteral, which, in potentially underestimating the correct dose, entails a readily remediable error.

†† The best dosing interval for methadone is uncertain. Despite a long plasma half-life (15-30 hours: Charles E. Inturrisi. *Narcotic Drugs*, in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control*, 66 THE MEDICAL CLINICS OF NORTH AMERICA 1061, 1065 (1982)). the analgesic effect parenterally often is

only as long as morphine (*e.g.*, 3-5 hours; personal communication from Raymond Houde, Jan. 1983). Yet, using methadone at such frequent intervals often leads to confusion in the first few days. In chronic use, methadone might be given frequently (every 4 hours) for the first 24 hours, then the interval reduced to 1-3 times per day or the dosage reduced; L. Paalzow. L. Nelson, and P. Stenberg. *Pharmacokinetic Basis for Optimal Methadone Treatment of Pain in Cancer Patients*, 74 ACTA ANESTH. SCAND. (Suppl.) 55 (1982). *See also*, J. Sawe *et al.*, *Patient-controlled Dose Regimen of Methadone for Chronic Cancer Pain.* 282 BRIT. MED. J. 771 (Mar. 1981); David S. Ettinger. Paul J. Vitale, and Donald Trump, *Important Clinical Pharmacologic Considerations in the Use of Methadone in Cancer Patients.* 63 CANCER TREATMENT REPORTS 457 (1979).

tt Robert G. Twycross, *Relief of Pain*, in Cicely M. Saunders, ed., THE MANAGEMENT OF TERMINAL DISEASE, Edward Arnold Publishers Ltd.. London (1978) at 66, 77-78. gives this interval for levophanol. Its pharmacokinetics and existing research base parallel methadone, though its structure is different and its plasma half-life is shorter (12-16 hours, Inturrisi, *supra* note t, at 1065). It may be similar in having a relatively brief analgesic effect, especially in the first few days of use, and a tendency to accumulate with detrimental mental effects unless dosage is reduced.

from outpatient pharmacies. The volume of narcotic for intramuscular use or the number of tablets for oral use can become unsettling to the physician or nurse and unacceptable to the patient. The professional should be reassured to know that some patients have required over 300 mg. of morphine orally every 3 hours and over 200 mg. intramuscularly every 2-3 hours. As long as the patient is awake and in pain, the dose is not too high. However, such high doses may entail many tablets or unacceptably large or frequent parenteral injections. To reduce the volumes for parenteral administration over commercially available solutions, crushed hypodermic morphine sulfate tablets can be dissolved in warmed sterile water. At some point, intravenous morphine may be better. Morphine can be added to dextrose or electrolyte solution in whatever concentration is necessary, usually 1 mg./ml. initially. To prevent accidental overdose, either an automated rate control device or a 1-2 hour infusion volume (as in a Soluset) should be used. These high doses are the only time when diamorphine (heroin) offers an advantage, since its potency and solubility are so much higher that parenteral volumes remain low.[13] Hydromorphone is also very soluble, but concentrated solutions must be made up from the powdered drug and filtered by a pharmacist.

For patients who seem to be stable for a period of weeks or months, a longer-acting narcotic is sometimes helpful. Either methadone or levorphanol can at times be given orally two or three times a day, thereby allowing the patient to sleep all night and to go about daily tasks without constantly attending to the next drug dose. Some patients use one of these most of

[13] Id. at 76-77. Diamorphine is not legally available in the United States.

the time but take a shorter-acting agent as a booster shortly before activities known to worsen pain, such as taking a bath or transferring from bed to chair. Methadone is reported to have a tendency to accumulate and induce oversedation or confusion.[14]

The physician should know approximate equivalences of the most common narcotics preparations and delivery routes so that switching among regimens is as smooth as possible (see Table B1, p. 281 *supra).* Cross-tolerance is fairly great, but not complete.[15] Thus it is wise to use about one-quarter less than the predicted dose of a new narcotic for the first dose, possibly with a supplement in an hour if needed.

All narcotics should be given on a fairly regular schedule aimed to anticipate the recurrence of pain by having each dose take effect just as the last one is waning. Sometimes patients who are getting adequate pain relief for too short a period respond better to increased frequency than to increased dosage. In settings where the nurse or other person directly caring for the patient understands the pharmacology involved, writing orders "prn" is reasonable, as it is interpreted to mean "as needed to prevent recurrence of pain without undue sedation." In the usual hospital setting where "prn" might be interpreted to mean "when pain recurs," narcotics should be given on a regular schedule and adjustments made on the basis of frequent observation by the physician.[16] When a previously adequate dosage schedule becomes inadequate and no remediable cause is found, the patient will often need a potentiating drug or to have the total dose of the current narcotic nearly doubled to regain good effect.

Whenever narcotics are used, certainly with dying patients, flexibility and confidence are increased by always having naloxone (Narcan, 0.4 mg./ml.) available. One milliliter (intravenous, intramuscular, or subcutaneous) will usually substantially reverse oversedation and respiratory depression, and that dosage may be repeated each **2-3** minutes until **3** ml. have been given.[17] Usually, just letting the patient sleep until a

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[14] *Id.* at 78; Kathleen M. Foley, *The Practical Use of Narcotic Analgesics,* in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1091, 1094-95 (1982). *See also* explanatory note tt, Table B1 at p. 281 *supra.*

[15] Raymond *W.* Houde, *The Use and Misuse of Narcotics in the Treatment of Chronic Pain,* in J.J. Bonica, ed., 4 ADVANCES IN NEUROLOGY, Raven Press, New York (1974) at 527.

[16] Marcia Angell, *The Quality of Mercy* (Editorial], 306 *NEW* ENG. J. **MED.** 98 (1982); Beaver, *supra* note 7, at 2655-56; for documentation of the current serious underutilization of narcotics, *see* Richard M. Marks and Edward Sachar, *Undertreatment of Medical Inpatients with Narcotic Analgesics,* 78 ANNALS INT. MED. 173 (1981).

[17] Jaffe and Martin, *supra* note 6, at 523-25. More tolerant and dependent patients are paradoxically sensitive to naloxone. There-

mild overdose is metabolized is appropriate, but using naloxone allows for more diagnostic certainty and protection against drug-induced respiratory insufficiency.

Narcotics commonly cause or worsen constipation and nausea, but these effects can be prevented and treated.[18] Pharmacologic agents to counteract constipation exacerbated by narcotics often are effective only at 2 to 3 times their usual dosage.

Concerns about dying patients becoming addicted to narcotics are both mistaken and, in any case, irrelevant. Few patients develop problems because of physical dependence. Furthermore, if the cause of pain is relieved, narcotics can be discontinued over a few days without untoward effects.[19] Furthermore, physical and psychological addiction, when it occurs, is not particularly troubling to a patient who is dying, nor should it be to care givers.

Other analgesics and potentiators. Acetaminophen, aspirin, and the group of nonsteroidal anti-inflammatory agents (including indomethacin and phenylbutazone) are often adequate for the control for pain. They act by different mechanisms than narcotics, with additive or supra-additive effects, thus allowing reduction in narcotic dosage in many cases.[20] Also, their anti-inflammatory effects may directly relieve some sources of pain such as arthritis, contractures, or wounds. Of course, the risks of side effects such as gastritis or gastrointestinal bleeding must be considered.

Agonist-antagonist drugs like pentazocine (Talwin), butorphanol (Stadol), and nalbuphine (Nubain) are potent analgesics, though they do have ceiling effects and tend to cause psychotomimetic effects at high dose. But butorphanol and nalbuphine are only available for parenteral use and have not been well evaluated in chronic pain of dying patients. Pentazo-

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fore, the standard naloxone preparation might best be diluted and administered in fractionated doses to reduce risk of inducing withdrawal and severe recurrent pain. For patients with tolerance, naloxone reversal is likely to have to be repeated over the ensuing few hours. Gilman, Goodman, and Gilman, *supra* note 6, at 523.

[18] *See* pp. 289-91 *infra*.

[19] Jane Porter and Hershel Jick, *Addiction Rare in Patients Treated with Narcotics,* 302 NEW ENG. J. MED. 123 (1980);Twycross, *supra* note 2, at 82-85.

[20] Thomas G. Kantor, *Control of Pain by Nonsteroidal Anti-Inflammatory Drugs,* in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1053 (1982); Charles G. Moertel, *Relief of Pain in the Cancer Patient.* in Stephen *K.* Carter, Eli Glatstein, and Robert B. Livingston, eds., PRINCIPLES OF CANCER TREATMENT, McGraw-Hill Book Co.. New York (1982) at 199; Twycross, *supra* note 2, at 72-73; R.W. Houde, **S.L.** Wallenstein, and N. Rogers, 1 **CLINICAL PHARMACOLOGY AND** THERAPEUTICS 163 (1960).

cine causes many adverse reactions, especially in the elderly, and is not especially flexible. A weaker tendency to cause addiction is not especially advantageous in dying patients; and, as these drugs are narcotic antagonists, they cannot be used in an integrated program with narcotics—one that relies on increasing efficacy of drugs as pain worsens or tolerance develops. Thus, pentazocine and other agonist-antagonist drugs have at this time little use in managing the pain of dying patients.[21]

Other drugs—such as hydroxyzine (Vistaril, Atarax)[22] and tricyclic antidepressants[23]—may potentiate narcotics. Usually patients with pain have reason for one or another of these, and the benefit of potentiation of narcotic effect is welcome. Theoretically, narcotic overdose could be induced in starting a potentiating drug, but this is rarely a problem. Benzodiazepenes and phenothiazines probably do not potentiate narcotics.[24]

Steroids, most commonly prednisone or dexamethasone, help control pain that arising in osseous metastases or fractures. Usually, maximum effect is at fairly low pharmacologic doses, about 2-4 mg. per day of dexamethasone or 10-20 mg. daily of prednisone.[25]

Neurosurgical and anesthetic methods. Localized pain, especially from pain fibers low in the spinal cord or in a limb, are sometimes accessible to temporary or permanent pain tract disruption.[26] Short-term blocks are useful for diagnosis but usually counterproductive for long-term pain control. Some initial testing of epidural morphine shows promise, however.[27]

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[21] Twycross, *supra* note 2, at 74.

[22] William T. Beaver and Grace Feise, *Comparison of Analgesic Effects of Morphine Sulfate, Hydroxyzine, and Their Combination in Patients with Postoperative Pain,* in J.J. Bonica and D. Albe-Fessard, eds., 1 ADVANCES IN PAIN RESEARCH AND THERAPY, New York, Raven Press (1976) at 553.

[23] Robert G. Twycross, *Overview of Analgesics,* in SYMPOSIUM ON PAIN, *supra* note 1, at 617, 622; Lawrence M. Halpern, *Psychotropics, Ataractics, and Related Drugs,* in *id.* at 279.

[24] J.W. Dundee and J. Moore, *The Myth of Phenothiazine Potentiation* 16 ANAESTHESIA 95 (1961); *but see,* Ross J. Baldessarini, *Drugs and the Treatment of Psychiatric Disorders,* in Gilman, Goodman, and Gilman, *supra* note 6 at 391,414.

[25] Twycross, *supra* note 23, at 625; Twycross, *supra* note 2, at 88-90.

[26] Robbie, *supra* note 1; Meyerson, *supra* note 1; Arner, *supra* note 1; Bolund, *supra* note 1.

[27] L. Mandaus, R. Blomberg, and E. Hammars, *Long-Term Epidural Morphine Analgesia,* 74 ACTA ANESTH. SCAND. (Suppl.) 149 (1982); Lawrence Sherman, Robert Milch, and George Cohn, *The Use of Epidural Morphine in a Hospice Setting,* presented at the Fifth Annual Meeting and Eighth Symposium of the National Hospice Organization, Washington, Nov. 9,1982.

Determining whether the destruction of a nerve, spinal cord tract, or brain center is warranted requires consultation with an experienced anesthesiologist and/or neurosurgeon. The patient considering an ablative procedure should be well aware of the likelihood and seriousness of the possible loss of additional neurologic functions. The patient should ordinarily have had a trial of vigorous nondestructive pain control.

A mixture of 50% nitrous oxide and 50% oxygen may be useful for patients with short-lived severe pain, as in dressing changes or movement.[28]

Mental Function

Preexisting disturbances. Patients who are dying are not all the same; severe depression, alcohol abuse, psychosis, dementia, and personality disorders are as prevalent among these patients as among others. Treatment of the symptoms of these disorders as the patient is dying will usually entail the same sorts of methods used with healthier patients: drugs, behavioral modification, environmental control, and so forth. People giving care to dying patients must be'Gspecially careful, however, to set reasonable goals and limits and to focus more on accepting these patients than on changing them.

Primary central nervous system disease. The changes in mental functions that patients dying of strokes, dementias, .or space-occupying intracranial lesions experience are often more disturbing to family members and care givers than to the patients themselves since they are often unaware of their situations. When these lesions cause distressing behavior, antispasmodic drugs or tranquilizers may be useful. When increased intracranial pressure could be a component, dexamethasone (2-32 mg. per day in 4-8 doses) may be tried,[29] though it has a number of potential side effects. If dexamethasone is successful, the dosage can be reduced to lowest effective level. If the intracranial process is enlarging, symptoms will recur and high doses might again be warranted. When dexamethasone no longer proves to be significantly beneficial, rapidly tapering it to baseline adrenal replacement (about 2 mg. per day) or lower is often warranted, as this allows the terminal phase to be mercifully brief.

Drugs and metabolic abnormalities. Hypercalcemia is a particularly common concomitant of malignancies and can cause myriad symptoms, the most common being confusion, disorientation, and sedation. If this occurs as the patient is

Twycross, *supra* note 2, at 98.

[29] Mary J. Baines, *Control of Other Symptoms*, in Saunders, *supra* note 1, at 99, 102-103; Plum recommends 16 mg. initially and 4 mg. every 6 hours, tapering if possible. Fred Plum. *Headache*, ,in James B. Wyngaarden and Lloyd H. Smith, eds., CECIL TEXTBOOK OF MEDICINE, W.B. Saunders Company, Philadelphia (16th ed. 1982) at 1948-49.

close to death anyway, it may be best to accept hypercalcemia without therapy, as few deaths are more gentle. However, if calcium rises when a patient might have a few weeks or more of valued life left, therapy may be warranted.[30] Increased fluids and furosemide (Lasix) often suffice; adrenocortical 'steriods and oral phosphates are also often effective. Sometimes mithramycin (Mithracin), even at as low a dose as 1-2 mg. intravenously once or twice a week, is effective. Calcitonin (Calcimar, 50-100 MRC daily or on alternate days) might also be used.

Since dying patients are often cachectic, vitamin-deficient, acidotic, hypo-osmotic, uremic, hypoalbuminemic, or hypoxic they are likely to experience mental changes from drugs that do not usually have such effects. Sedatives and tranquilizers are obviously common culprits, but so are cimetidine, digoxin, tricyclic antidepressants, theophylline, steroids, and other "medical" drugs. Narcotics rarely cause confusion without concomitant severe sedation, though some patients find all narcotics to be dysphoric. When changes in a patient's mental status interfere with the patient and family living as fully as possible, each drug that could be causing the mental change should be reduced as much as possible to test whether mental function is improved.

Metabolic abnormalities like hypoxia, hepatic failure, renal failure, acidemia, hypokalemia, hypomagnesemia, and dehydration are not uncommon causes of mental disturbances and might be remediable.

Anxiety and depression. Some anxiety and depression are normal in dying patients. Most of what is truly troublesome to the individual is best relieved by simple psychological support, pain control, attention to legal, social, and financial problems, and so forth.[31]

Free-floating anxiety or persistent depression can have crippling effects on some patients. Fortunately, both commonly respond to fairly mild pharmacologic agents and supportive psychotherapy.[32] Many patients benefit from fairly low doses of tricyclic antidepressants.[33] A dose as low as 20-30 mg. of doxepin (Sinequan] or nortriptyline at bedtime often encour-

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[30] Baines, *supra* note 29, at 101; Zimmerman, *supra* note 10, at 68.

[31] Colin M. Parkes, *Psychological Aspects,* in Saunders, *supra* note 1, at 44.

[32] *Id.* at 56-57; Baines, *supra* note 29, at 114; Peter G. Wilson, *Anxiety and Depression in Elderly and Dying Patients,* in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1011,1015(1982).

[33] Alexander H. Glassman and Steven P. Roose, *Tricyclic Drugs in the Treatment of Depression,* in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1037,1040(1982).

ages a good night's sleep, reduces anxiety, and improves appetite.

Numerous other anxiolytic agents can be used: antihistamines, benzodiazepines, phenothiazines, and so forth. Often, one or another is indicated for a separate reason; prochlorperazine (Compazine), for example, is used to reduce both nausea and anxiety. Benzodiazepines are somewhat risky as they have a long half-life and a fairly high incidence of causing confusion or sedation.'' Hydroxyzine (Vistaril or Atarax, 10-25 mg. every 6-8 hours) has some advantages in that it potentiates narcotics, reduces nausea, can be given orally or parenterally, is fairly effective, and has few sedative or anticholinergic side effects even in elderly or debilitated patients.

Gastrointestinal Symptoms

Anorexia and dysphagia. For a patient to find himself or herself uninterested or averse to food can be quite disconcerting for the person, and often even more so to family members. However, substantial anorexia is almost the norm in the later stages of terminal illness. Sometimes counseling family and patient to accept a loss of appetite is extremely helpful. An altered sense of taste or smell is sometimes part of the cause of anorexia. Stronger flavors, careful menu selection, and good mouth care may help.

Other interventions include a little of the patient's favorite alcoholic beverage (or Gevrabon,. which contains vitamins dissolved in sherry) 30 minutes before meals, small and attractive-looking meals on a flexible schedule, a vitamin and mineral supplement, high-calorie milk shakes or prepared dietary supplements, low-dose steriods *(e.g.,* 1 mg. dexamethasone or 5 mg. prednisone three times daily), or tricyclic antidepressants.[35]

Only rarely should a dying patient be fed by tube or intravenously. When neurologic or structural disease of the mouth or esophagus precludes the swallowing of food, tube feeding might be warranted if chosen by an individual on a well-informed basis.[36] When initiating any sort of artificial feeding with a dying patient, the practitioner would do well to talk with the person and/or family about indications that would warrant its discontinuation.

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[34] B. Robert Meyer, *Benzodiazepines in the Elderly,* in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control,* **66** THE MEDICAL CLINICS OF **NORTH** AMERICA **1017 (1982).**

[35] Zimmerman, *supra* note **10,** at **69-70.**

[36] Michael R. Williams, *The Place of Surgery in Terminal Care,* in Saunders, *supra* note 1, at **134, 136;** Zimmerman, *supra* note 10, at 70-**71.** *But see* Joyce V. Zerwekh, *The Dehydration Question.* **Nursing83** 47 (1983), which argues that dehydration is normal and prevents distressing symptoms in the last few days of life.

In the unusual case where dysphagia is due to candidiasis or is avoidable by the justified use of a feeding tube, dysphagia is remediable. More commonly, a feeding tube is not warranted and the cause is not correctable; sedation and pain relief may then be all that is indicated.

Problems with the mouth. Much avoidable distress arises from inattention to the mouth.[37] Early in the course of a predictably fatal illness, patients should be encouraged to have dental care. Abcesses, exposed roots, and ill-fitting dentures are likely to be more of a problem as the patient loses weight and fights infections less successfully. Dentures should be used as long as possible despite receding gums, especially since patients often feel ashamed to be seen without them. Regular brushing of the teeth and cleaning of the mouth can often improve the patient's self-image greatly. Candidiasis is usually easy to diagnose and treat, using nystatin (Mycostatin) either as a suspension or as oral tablets (5 ml. to swish, or one oral tablet to suck and swallow 3-4 times a day).

Dehydration, head and neck surgery, radiation to the face and neck, mouth breathing, narcotics, and anticholinergics make dry mouth a common problem. Frequent tooth brushing and mouth rinsing help, as do sipping liquids, sucking on ice, or sucking on hard candies. Commercial artificial saliva (Moi-Stir) or a specially prepared mixture of methylcellulose and glycerin or lemon essence can also be helpful.[38]

The inability to speak or to speak clearly is often very distressing to patients, families, and care givers. The usual methods of speech therapy—sign boards, typewriters, note pads, and lip reading—generally suffice to restore some communication. Often, however, care givers must be even more willing than normal to try to guess the patient's concerns and to initiate the relevant conversations.

Nausea and vomiting. Many seriously ill patients have nausea and vomiting. Sometimes the cause can be corrected. If not, prochlorperazine (Compazine) or a related phenothiazine is usually the most effective therapy. Doses can be clustered (*e.g.*, 5 mg. every 20 minutes up to 4 doses, to repeat every 6 hours as needed) in response to intermittent symptoms or can be scheduled (*e.g.*, 10-20 mg. orally or intramuscularly every 8 hours or 25 mg. per rectum every 6 hours) in response to more continuous symptoms.[39]

Delta-9-tetrahydrocannabinol (THC) is a component of marijuana that is showing promise in early investigations

[37] Austin H. Kutscher, Bernard Schoenberg, and Arthur C. Carr, THE TERMINAL PATIENT: ORAL CARE, Columbia Univ. Press, New York (1973).
[38] Baines, *supra* note 29, at 99-100.
[39] Zimmerman, *supra* note 10, at 71.

concerning nausea and vomiting associated with chemotherapy.[40] Oral metoclopramide (Reglan) may be useful to treat nausea and vomiting if gastric atony and reduced intestinal motility are contributing causes.[41] Sometimes an antihistamine *(e.g.,* dimenhydrinate (Dramamine)) can be helpful also.

Intestinal obstruction. Some nausea and vomiting originate with intestinal obstruction. If the obstruction is from fecal impaction, cathartics, enemas, manual disimpaction, and hydration may solve the problem. With other causes, abdominal surgery will have to be considered. In addition to nausea and vomiting, intestinal obstruction can cause pain, infection, dehydration, and malnutrition.

One need not always try to relieve the obstruction, however. When the obstruction is unifocal and low and the patient could otherwise live for some weeks or months, a diverting colostomy may be helpful palliation. But when the obstruction is multifocal or high or when a patient has at best only a few weeks to live, it may be best to treat the symptoms only.[42] The pain and hyperperistalsis will usually respond to adequate use of narcotics. Antiemetics and frequent small feedings allow for some absorption, and most patients remain quite comfortable until death, often without nasogastric suctioning or intravenous fluids.

Constipation and diarrhea. Decreased bulk in the diet, inactivity, abdominal disease, metabolic imbalance, dehydration, anticholinergic 'drugs, and narcotics combine to make constipation the norm for dying patients. Untreated, constipation can cause bowel obstruction, diarrhea, fever, pain, and confusion. Obviously, bowels should receive close attention. Stool softeners such as dioctyl sodium sulfosuccinate (Colace) or psyllium hydrophilic muciloid (Metamucil) should be given regularly. Stimulants such as casanthranol (as in Peri-Colace), senna derivatives (Senokot), cascara sagrada, or bisacodyl (Dulcolax) should be added as needed. Mineral oil, milk of magnesia, or other agents may be preferred by some patients.

If no stools are passed for three days, a rectal examination is in order. If stool is present but not impacted, the digital exam, glycerin suppositories, bisacodyl suppositories, and prepackaged enemas should be used, probably in about that sequence. No stool by the fourth day should elicit the same response, with the addition of vigorous enemas (soap suds, warm oil, or high volume). With assiduous attention and

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[40] *Id.*

[41] Baines, *supra* note 29, at 103; Riyad Albibi and Richard McCallum, *Metoclopramide: Pharmacology and Clinical Application,* 98 ANN. INT. MED. 86 (1983).

[42] Zimmerman, *supra* note 10, at 71-72; Baines, *supra* note 29, at 101-02.

vigorous efforts, nearly all patients can avoid the complications of constipation.[43]

Diarrhea is a less common problem, but it may be caused by diabetes, antibiotics, underlying malabsorption, and fecal impaction. If it is due to pancreatic insufficiency, diarrhea can be dramatically relieved by replacement enzymes.[44] If the cause cannot be removed, the diarrhea can usually be stopped with diphenoxylate with atropine (Lomotil, 1or 2 tablets after each stool, up to 8 per day) or loperamide (Imodium, 2-4 mg. after each stool up to 16 mg. per day).

Ascites. Ascites is often asymptomatic despite being dramatic. When troubling, cirrhotic ascites may respond to the usual diuretics or the less usual shunting. Malignant ascites often is well controlled by instillation of chemotherapeutic agents or by frequent paracenteses, which are both well tolerated.[45]

Skin Problems

Decubitus ulcers. Cachectic, immobile, and bedbound patients are at great risk of developing skin sores. Few patients without them realize how distressing these lesions can be. Prevention, or at least a delay in their onset, is much more satisfactory for patients than efforts to heal an established decubitus ulcer. Frequent turning, skin massage, padding around prominent bones and ears, and redoubled efforts if the skin starts to redden are the hallmarks of prevention. Immobile patients should have heel protectors and one of the various special mattresses (egg-crate, water bed, air mattresses, or the like). For some patients, an overhead trapeze is an invaluable encouragement to make frequent position changes.

Few decubiti in dying patients heal. Once the skin breaks, usually all that can be done is to keep infection from being serious and to keep the lesion from enlarging. Usually about once a month, cellular debris needs to be cleared with a week of wet-to-dry dressings or sharp dissection. Various local therapies are promoted, though none has been shown to be distinctly superior in controlled trials.[46]

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[43] Baines, *supra* note 29, at 104-05; Harvey Klein, *Constipation and Fecal Impaction,* in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1135 (1982).

[44] Baines, *supra* note 29, at 105.

[45] Charles G. Moertel, *The Peritoneum,* in James F. Holland and Emil Frei, III, eds., CANCER MEDICINE, Lea & Febiger, Philadelphia (1973) at 1631,1632.

[46] James B. Reuler and Thomas G. Cooney, *The Pressure Sore: Pathophysiology and Principles of Management,* 94 ANNALS *INT.* MED. 661; Joseph Agris and Melvin Spira, *Pressure Ulcers: Prevention and Treatment,* 31 CLINICAL SYMPOSIA **5, 7** (1979).

Other open lesions. Some patients have fistulas or sinuses whose care presents a problem. Sometimes excision, amputation, or diversion of the contents of the originating viscera are beneficial. Otherwise, local care of the affected skin will often require creative efforts. Sometimes a *de facto* stoma can be created.

Extensive malignant ulcerations pose another dramatic nursing challenge. The goals should be to reduce cosmetic distress, to keep the lesion clean and odor-free, and to avoid serious infection or hemorrhage. There is no substitute for gentle, thorough cleansing and dressing, usually twice a day. Half-strength hydrogen peroxide or Dakin's solution seem to be well tolerated and mildly bactericidal. If odor is a problem, powdered tetracycline (from a capsule) is quite effective when sprinkled over the lesions before dressing. If minor bleeding occurs, pressure, gelfoam, or powdered thrombin may help. Suture material should be available for efforts to tie major middle-size arteries that bleed, though rupture of a major artery is often best managed with an abundance of towels,[47] since repair or ligature is so likely doomed and the patient is so rapidly unconscious. If the patient is frightened, parenteral morphine, hyoscine, or diazepam (Valium) will provide rapid tranquilization and also fairly reliable amnesia if the patient survives.[48] Some attention should be given to making all dressings cosmetically acceptable, especially on the neck, face, and hands. Creative application of dressings can mask the absence or distortion of cheek, jaw, or eye, and thereby keep it easier for visitors to see the patient, and for the patient to see a mirror.

Pruritus. The itching associated with malignancy usually has no definite treatable origin. Pruritus of biliary obstruction sometimes responds to cholestyramine (Questran). Some pruritus is caused by drugs, soaps and lotions, or other allergens. If no specific cause can be remedied, antihistamines such as hydroxyzine (Vistaril), phenothiazines such as trimeprazine (Temaril), or topical or systemic steriods may be of some help.[49] Relief is reported to last a day or two after intravenous

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[47] "[The patient at risk of hemorrage] should be encouraged to pursue his normal activities. It is, however, kind to arrange for the traditional red blanket to be draped about him to lessen the distress of any onlookers if a large bleed ensues:" Williams, *supra* note 36, at 137.

[48] Cicely Saunders, *Principles of Symptom Control in Terminal Care,* in Marcus Reidenberg, ed., *Clinical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1169, 1178 (1982).

[49] *Id.* at 1177; Richard K. Winkelmann, *Pharmncologic Control of Pruritus,* in Marcus Reidenberg, in C*linical Pharmacology of Symptom Control,* 66 THE MEDICAL CLINICS OF NORTH AMERICA 1119 (1982).

use of local anesthetics.[50]

Fever. History and physical exam are especially helpful in distinguishing among the very different possible etiologies of fever—especially dehydration, constipation, central nervous system lesions, urinary infection, or pneumonia. The causative etiology can generally be treated. Furthermore, usually the patient benefits from antipyretics, increased fluid intake (if possible), and alcohol sponge baths. If the fever probably results from an overwhelming bacterial infection, with falling blood pressure and obtundation, treatment may appropriately be withheld, including not giving antibiotics, intravenous volume expansion, or pressors. Symptomatic urinary tract infection rarely is overwhelming but can be quite distressing, thus nearly always warranting antibiotic therapy.[51]

Weakness. Most dying people feel weak; oddly, many people need to be reassured that weakness is acceptable. Appropriate use of antidepressants and pain control drugs sometimes helps to ameliorate weakness. Transfusions for profound anemia are sometimes dramatically beneficial. Steroid effects, uremia, hepatic encephalopathy, hypercarbia, and hypoxia are often partially treatable. Anabolic hormones like nandrolone decanoate (Deca-Durabolin) or fluoxymesterone (Halotestin) or adrenocortical steriods like prednisone or dexamethasone (Decadron) are sometimes beneficial. Central nervous system stimulants like methylphenidate (Ritalin) have been reported to benefit a few patients, but the incidence of confusion is fairly high.[52]

Respiratory Symptoms. Few symptom groups are so frustrating as hiccups, cough, and dyspnea. Patients with serious disease rarely respond to the "first-aid" measures to stop hiccups. Amphetamines, phenothiazines, haloperidol, or metoclopramide sometimes work.[53] Phrenic nerve block is usually effective but sometimes fails and always compromises respiratory reserve.

Coughing might arise from treatable causes—pleural effusion, pulmonary embolus, dehydration of the bronchi, pneumonia, or thick sputum. Often, however, humidifiers, potassium iodide, chest physical therapy, and other remedial measures do not help. Cough might be suppressed by terpin hydrate with codeine, hycodan, or with stronger narcotics. Using viscous

[50] H.U. Gerbershagen, in SYMPOSIUM ON PAIN, *supra* note 1, at 301-02; Luis Tapia *et al.*, *Pruritus in Dialysis Patients Treated with Parenteral Lidocaine*, 296 NEW ENG. J. MED. 261 (1977).
[51] Zimmerman, *supra* note 10, at 73.
[52] *Id.* at 67-68; Twycross, *supra* note 2, at 80-81.
[53] Baines, *supra* note 29, at 106; Zimmerman, *supra* note 10, at 73.

lidocaine (Xylocaine) and other local anesthetics as a gargle or sucking on hard candies may help for a short time."

Whether or not to treat pneumonia with antibiotics depends upon the patient's situation.[55] Pneumonia may sometimes be the "old man's friend," as it is often called, and could well be acceptable, with cough and dyspnea controlled by morphine. Sometimes, though, even in a patient expected to die soon, antibiotics, chest physical therapy, and oxygen are better.

No symptom is so terrifying as dyspnea. Usually any remediable cause—pleural fluid, congestive heart failure, anemia, and bronchospasm, for example—should be sought.[56] Positioning the patient in a semirecumbent position, blowing cool air over his or her face, and judicious use of oxygen often help. Radiation to the mediastinurn and dexamethasone (4 mg. every *6* hours) may help if the etiology is mediastinal tumor. Even if pain is not a problem, low-dose narcotics help, either by reducing anxiety, by reducing pulmonary vasocongestion, or by dulling the medullary reflexes.[57] A few milligrams of morphine every 3-4 hours or about 5 mg. at bedtime can greatly add to the patient's comfort without causing any deleterious effect on respiratory effort. Dyspnea as a terminal event is discussed in the next section. When a dying patient is on a respirator, rather rapid and controlled weaning is sometimes indicated; such weaning should proceed with symptom control but without trying to maintain respiratory function.[58]

Agonal symptoms. The symptoms discussed thus far generally apply to patients who are within a few months of death. Sometimes the last few hours and minutes present some additional symptoms that can be treated.

Agonal respiratory insufficiency. No death is more agonizing for the aware patient and all around him or her than one from respiratory insufficiency. Untreated, the patient will struggle for air until exhausted, when carbon dioxide narcosis and progressive hypoxia finally bring death fairly quickly. The patient must sit, can barely speak, and can continue in this way for hours or even a few days. In this situation, the care giver must be certain that no specific remedy—diuretics,

[54] Zimmerman, *supra* note 10, at 72-73.
[55] Baines, *supra* note 29, at 108-09.
[56] However, in discussing bronchial carcinomtt, some advocate not using thoracentesis or intrapleural cytotoxic agents but instead relying upon morphine for dyspnea. *See* Bates and Vanier, *supra* note **1,** at 132.
[57] Twycross, *supra* note 2, at 79.
[58] Ake Grenvik, *Terminal Weaning: Discontinuance of Life-Supporting Therapy in the Terminally Ill Patient* (Editorial), 11 **CRIT. CARE MED.** (forthcoming, May 1983).

oxygen, thoracentesis, and so on—is warranted to relieve the respiratory insufficiency.[59] Then, with the appropriate consent by the patient and family, morphine can be given intramuscularly in small doses (for a patient who has not developed any tolerance, 3-5 mg. in each dose] every 15-20 minutes until some relief is obtained. Usually, the patient's breathing will slow slightly and become a little deeper and his or her terror will subside. No more morphine may be needed. If the patient is already quite exhausted, the slowed respirations will induce hypercapnia, which will perpetuate the sedation and the patient will die in the ensuing sleep. If the patient has more reserve, the severe dyspnea will probably recur, and can again be treated with morphine. Although this approach is far from perfect, it does allow the physician to improve upon what is otherwise a singularly terrifying and agonizing final few hours.

Aesthetic considerations. Even when a patient is beyond caring about how others remember his or her last hours, this period can have serious effects on family, friends, and care givers. Usually it is important to keep the "death bed" as aesthetic as possible. This entails considering the sensory impressions presented by the patient and surroundings.

The visual impression should, as far as possible, be one of peace and privacy. Attentive nursing can minimize disruption caused by emesis or bleeding. Agonal seizures or muscle twitches are usually minor and brief, but respond to intramuscular diazepam (Valium) if needed. Emaciation, artificial tubes, and various wounds can be disguised with skillful use of sheets and bedspreads.

Masking unpleasant odors by putting extra sheets over wounds and incontinence, ensuring good air circulation, and using pleasant odors helps family members to stay with the patient.

Some patients develop a noisy bronchial congestion or relaxation of the soft tissues shortly before death—the well-known "death rattle." If this is distressing to the family (it never seems to be present in patients awake enough to be distressed by it), scopolamine or atropine (0.4 mg. of either by injection), added to a narcotic, is usually sufficient to make the patient sound better.[60]

Patients, care givers, and family members seem to benefit from maintaining physical contact as the end of life nears. Family members may need to be asked if they would like to hold the patient's hand or wipe the forehead, as they are commonly uncertain about what they can or should do.

[59] Baines, *supra* note 29, at 109-10; Saunders, *supra* note 48, at 1175-76.
[60] Baines *supra* note 29, at 110.

Bereavement

The responsibilities of those who cared for the patient who died do not end with that person's death. It is well known that the death of a loved one is a stressful event that can lead to premature death, increased morbidity, and psychological difficulties for survivors.[61] Health care professionals who cared for the patient will often have come to know that person's family during the patient's illness. They are therefore well situated to observe behavior patterns, emotional reactions, and social circumstances that may signal difficulty during bereavement.

Although the majority of people grieve "normally" and return to adequate levels of functioning within a reasonable period, many people need support during bereavement and some people (variously estimated at **10-20%)** will be unable to resolve their grief on their own and will benefit from professional help. Research has shown that people who lack social supports, whose relationships with the deceased involved ambivalent feelings, who suffered a completely unexpected loss, or who have preexisting physical or psychological disorders are at high risk for pathological grief.[62] Furthermore, the circumstances surrounding the death itself and the particular person who dies may render the survivors especially vulnerable. The death of a child, for example, is generally extremely stressful for parents and siblings and is likely to require special attention. Health professionals are likely to learn of these circumstances while they are caring for the patient, which should trigger the professionals' attention later to signs that the survivors are encountering difficulties that may warrant help.

Although the health care professionals who cared for the patient need not also assume full responsibility for the care of survivors, it is their responsibility to be aware of signs of

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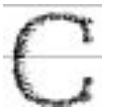
[61] *See e.g.,* T.H. Holmes and R.H. Rake, *The Social Readjustment Rating Scale,* 11 J. PSYCHOSOMATIC RES. 213 (1967); K.J. Helsing and M. Szklo, *Mortality After Bereavement,* 114 AM. J. EPIDEMIOLOGY 41 (1981); C.M. Parkes and R. Brown, *Health After Bereavement: A Controlled Study of Young Boston Widows and Widowers,* 34 PSYCHOSOMATIC MED. 449 (1972); G.L. Klerman and J.E. Izen, *The Effects of Bereavement and Grief on Physical Health and General Well-Being,* 9 ADVANCES IN PSYCHOSOMATIC MED. 1, 41(1977).

[62] Beverly Raphael, *Preventive Intervention with the Recently Bereaved,* 34 ARCHIVES GEN. PSYCHIATRY 1450 (1977); Robert S. Weiss, *Recovery from Bereavement: Findings and Issues,* presented at NIH Professional Conference, Nov. 1982, at 6 (summary of findings in Colin Murray Parkes and Robert S. Weiss, RECOVERY FROM BEREAVEMENT, Basic Books, New York (in press)); Mary L.S. Vachon *et al., Predictors and Correlates of Adoption to Conjugal Bereavement,* 139 AM. J. PSYCHIATRY 998 (1982); Paula J. Clayton, *Bereavement and its Management,* in *E.S.* Paykel, ed., HANDBOOK OF AFFECTIVE DISORDERS, Churchill Livingstone, Edinburgh (1982) at Chapter 31.

pathologic grief, to have enough contact with survivors to detect the need for further help, and to be knowledgeable about community resources and professional services, so they can refer survivors to these resources if needed. In addition, part of the role of health care professionals and institutions is to respect, insofar as possible, the needs of a culturally and religiously diverse population. This means seeking out and respecting the family's wishes with regard to autopsy, disposition of the body, and possible funeral arrangements.

This Appendix was prepared by the Commission's Assistant Director for Medical Studies, Joanne Lynn, M.D., who wishes to acknowledge the helpful reviews and advice of several commissioners, of Drs. William T. Beaver, Paul Beeson, Raymond Houde, Fred Plum, Cicely Saunders, Thomas Walsh and Jack M. Zimmerman, and of the nursing staff of the Washington Home Hospice. Similar material is to be published in John R. Walsh and Christine K. Cassel, eds., GERIATRIC MEDICINE: PRINCIPLES AND PRACTICES, Springer-Verlag, New York (1983).

Statements by the AMA and the Catholic Church



Judicial Council, American Medical Association*

S 2.10 Quality of Life.

In the making of decisions for the treatment of seriously deformed newborns or persons who are severely deteriorated victims of injury, illness or advanced age, the primary consideration should be what is best for the individual patient and not the avoidance of a burden to the family or to society. Quality of life is a factor to be considered in determining what is best for the individual. Life should be cherished despite disabilities and handicaps, except when prolongation would be inhumane and unconscionable. Under these circumstances, withholding or removing life supporting means is ethical provided that the normal care given an individual who is ill is not discontinued.

In desperate situations involving newborns, the advice and judgment of the physician should be readily available, but the decision whether to exert maximal efforts to sustain life should be the choice of the parents. The parents should be told the options, expected benefits, risks and limits of any proposed care; how the potential for human relationships is affected by the infant's condition; and relevant information and answers to their questions. The presumption is that the love which parents usually have for their children will be dominant in the decisions which they make in determining what is in the best interest of their children. It is to be expected that parents will

* Selections from OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION, Dr. John H. Burkhart, Chairman, American Medical Association, Chicago (1982) at 9-10.

act unselfishly, particularly where life itself is at stake. Unless there is convincing evidence to the contrary, parental authority should be respected.

S 2.11 Terminal Illness.

The social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have discretion to resolve the conflict.

For humane reasons, with informed consent a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to let a terminally ill patient die, but he should not intentionally cause death. In determining whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient, the physician should consider what the possibility is for extending life under humane and comfortable conditions and what are the wishes and attitudes of the family or those who have responsibility for the custody of the patient.

Where a terminally ill patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support may be discontinued. If death does not occur when life support systems are discontinued, the comfort and dignity of the patient should be maintained.

Declaration on Euthanasia, the Sacred Congregation for the Doctrine of the Faith*

Introduction

The rights and values pertaining to the human person occupy an important place among the questions discussed today. In this regard, the Second Vatican Ecumenical Council solemnly reaffirmed the lofty dignity of the human person, and in a special way his or her right to life. The Council therefore condemned crimes against life "such as any type of murder, genocide, abortion, euthanasia, or wilful suicide" (Pastoral Constitution *Gaudium et Spes*, 27).

More recently, the Sacred Congregation for the Doctrine of the Faith has reminded all the faithful of Catholic'teaching on procured abortion.' The Congregation now considers it opportune to set forth the Church's teaching on euthanasia.

* **Vatican City (May 5,1980).**

[1] *Declaration on Procured Abortion,* **18 November 1974: AAS 66 (1974), pp. 730-747.**

It is indeed true that, in this sphere of teaching, the recent Popes have explained the principles, and these retain their full force;[2] but the progress of medical science in recent years has brought to the fore new aspects of the question of euthanasia, and these aspects call for further elucidation on the ethical level.

In modern society, in which even the fundamental values of human life are often called into question, cultural change exercises an influence upon the way of looking at suffering and death; moreover, medicine has increased its capacity to cure and to prolong life in particular circumstances, which sometimes give rise to moral problems. Thus people living in this situation experience no little anxiety about the meaning of advanced old age and death. They also begin to wonder whether they have the right to obtain for themselves or their fellowmen an "easy death", which would shorten suffering and which seems to them more in harmony with human dignity.

A number of Episcopal Conferences have raised questions on this subject with the Sacred Congregation for the Doctrine of the Faith. The Congregation, having sought the opinion of experts on the various aspects of euthanasia, now wishes to respond to the Bishops' questions with the present Declaration, in order to help them to give correct teaching to the faithful entrusted to their care, and to offer them elements for reflection that they can present to the civil authorities with regard to this very serious matter.

The considerations set forth in the present document concern in the first place all those who place their faith and hope in Christ, who, through his life, death and Resurrection, has given a new meaning to existence and especially to the death of the Christian, as Saint Paul says: "If we live, we live to the Lord, and if we die, we die to the Lord" (*Rom* 14:8; cf. *Phil* 1:20).

As for those who profess other religions, many will agree with us that faith in God the Creator, Provider and Lord of

[2] Pius XII, *Address to those attending the Congress of the International Union of Catholic Women's Leagues,* 11 September 1947: **AAS** 39 (1947), p. 483: *Address to the Italian Catholic Union of Midwives,* 29 October 1951: AAS 43 (1951), pp. 835-354; *Speech to the members of the International Office of military medicine documentation,* 19 October 1953: AAS 45 (1953), **pp.** 744-754; *Address to those taking part in the IXth Congress of the Italian Anaesthesiological Society,* 24 February 1957: AAS 49 (1957), p. 146; cf. also *Address on "reanimation,"* 24 November 1957: **AAS** 49 (1957), pp. 1027-1033; Paul VI, *Address to the members of the United Nations Special Committee on Apartheid,* 22 May 1974: **AAS** 66 (1974), p. 346; John Paul II: *Address to the Bishops of the United States of America,* 5 October 1979: **AAS** 71 (1979), **p.** 1225.

life—if they share this belief—confers a lofty dignity upon every human person and guarantees respect for him or her.

It is hoped that this Declaration will meet with the approval of many people of good will, who, philosophical or ideological differences notwithstanding, have nevertheless a lively awareness of the rights of the human person. These rights have often in fact been proclaimed in recent years through declarations issued by International Congresses;[3] and since it is a question here of fundamental rights inherent in every human person, it is obviously wrong to have recourse to arguments from political pluralism or religious freedom in order to deny the universal value of those rights.

The Value Of Human Life

Human life is the basis of all goods, and is the necessary source and condition of every human activity and of all society. Most people regard life as something sacred and hold that no one may dispose of it at will, but believers see in life something greater, namely a gift of God's love, which they are called upon to preserve and make fruitfu1,:And it is this latter consideration that gives rise to the following consequences:

1. No one can make an attempt on the life of an innocent person without opposing God's love for that person, without violating a fundamental right, and therefore without committing a crime of the utmost gravity.[4]

2. Everyone has the duty to lead his or her life in accordance with God's plan. That life is entrusted to the individual as a good that must bear fruit already here on earth, but that finds its full perfection only in eternal life.

3. Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on the part of a person is to be considered as a rejection of God's sovereignty and loving plan. Furthermore, suicide is also often a refusal of love for self, the denial of the natural instinct to live, a flight from the duties of justice and charity owed to one's neighbour, to various communities or to the whole of society—although, as is generally recognized, at times there are psychological factors present that can diminish responsibility or even completely remove it.

However, one must clearly distinguish suicide from that sacrifice of one's life whereby for a higher cause, such as God's glory, the salvation of souls or the service of one's brethren, a

[3] One thinks especially of Recommendation 779 (1976) on the rights of the sick and dying, of the Parliamentary Assembly of the Council of Europe at its XXVIIth Ordinary Session, cf. Sipeca, No. 1, March 1977, pp. 14-15.

[4] We leave aside completely the problems of the death penalty and of war, which involve specific considerations that do not concern the present subject.

person offers his or her own life or puts it in danger (cf. Jn 15: 14).

Euthanasia

In order that the question of euthanasia can be properly dealt with, it is first necessary to define the words used.

Etymologically speaking, in ancient times *euthanasia* meant an *easy death* without severe suffering. Today one no longer thinks of this original meaning of the word, but rather of some intervention of medicine whereby the sufferings of sickness or of the final agony are reduced, sometimes also with the danger of suppressing life prematurely. Ultimately, the word *euthanasia* is used in a more particular sense to mean "mercy killing", for the purpose of putting an end to extreme suffering, or saving abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years, of a miserable life, which could impose too heavy a burden on their families or on society.

It is therefore necessary to state clearly in what sense the word is used in the present document.

By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used.

It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a foetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. Nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity.

It may happen that, by reason of prolonged and barely tolerable pain, for deeply personal or other reasons, people may be led to believe that they can legitimately ask for death or obtain it for others. Although in these cases the guilt of the individual may be reduced or completely absent, nevertheless the error of judgment into which the conscience falls, perhaps in good faith, does not change the nature of this act of killing, which will alwavs be in itself something to be reiected. The pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact it is almost always a case of an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick

person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses.

The Meaning of Suffering for Christians nnd the Use of Painkillers

Death does not always come in dramatic circumstances after barely tolerable sufferings. Nor do we have to think only of extreme cases. Numerous testimonies which confirm one another lead one to the conclusion that nature itself has made provision to render more bearable at the moment of death separations that would be terribly painful to a person in full health. Hence it is that a prolonged illness, advanced old age, or a state of loneliness or neglect can bring about psychological conditions that facilitate the acceptance of death.

Nevertheless the fact remains that death, often preceded or accompanied by severe and prolonged suffering, is something which naturally causes people anguish.

Physical suffering is certainly an unavoidable element of the human condition; on the biological level, it constitutes a warning of which no one denies the usefulness; but, since it affects the human psychological makeup, it often exceeds its own biological usefulness and so can become so severe as to cause the desire to remove it at any cost.

According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's Passion and a union with the redeeming sacrifice which he offered in obedience to the Father's will. Therefore one must not be surprised if some Christians prefer to moderate their use of painkillers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified (cf. *Mt* 27:34). Nevertheless it would be imprudent to impose a heroic way of acting as a general rule. On the contrary, human and Christian prudence suggest for the majority of sick people the use of medicines capable of alleviating or suppressing pain, even though these may cause as a secondary effect semiconsciousness and reduced lucidity. As for those who are not in a state to express themselves, one can reasonably presume that they wish to take these painkillers, and have them administered according to the doctor's advice.

But the intensive use of painkillers is not without difficulties, because the phenomenon of habituation generally makes it necessary to increase their dosage in order to maintain their efficacy. At this point it is fitting to recall a declaration by Pius XII, which retains its full force; in answer to a group of doctors who had put the question: "Is the suppression of pain and consciousness by the use of narcotics ...permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics

will shorten life)?", the Pope said: "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes".[5] In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine.

However, painkillers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. Thus Pius XII warns: "It is not right to deprive the dying person of consciousness without a serious reason".[6]

Due Proportion. in the Use of Remedies

Today it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against a technological attitude that threatens to become an abuse. Thus, some people speak of a "right to die", which is an expression that does not mean the right to. procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity. From this point of view, the use of thereapeutic means can sometimes pose problems.

In numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied. In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case.

Everyone has the duty to care for his or her own health or to seek such care from others. Those whose task it is to care for the sick must do so conscientiously and administer the remedies that seem necessary or useful.

However, is it necessary in all circumstnaces to have recourse to all possible remedies?

In the past, moralists replied that one is never obliged to use "extraordinary" means. This reply which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of "proportionate" and "disproportionate" means. In any case, it will be possible to make a correct judgment as to the means by

[5] **Pius XII,** *Address* of 24 **February** 1957; **AAS 49 (1957),**, **p.** 147.
[6] Pius XII, *ibid.*, **p.** 145; cf. *Address* of 9 **September** 1958: **AAS** 50 (1958), **p.** 694.

studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.

In order to facilitate the application of these general principles, the following clarifications can be added:

If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity.

It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. But for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter. The latter may in particular judge that the investment in instruments and personnel is disproportionate the the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques.

It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger.

Conclusion

The norms contained in the present Declaration are inspired by a profound desire to serve people in accordance with the plan of the Creator. Life is a gift of God, and on the other hand death is unavoidable; it is necessary therefore that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity. It is true that death marks the end of our earthly existence, but at the

same time it opens the door to immortal life. Therefore all must prepare themselves for this event in the light of human values, and Christians even more so in the light of faith.

As for those who work in the medical profession, they ought to neglect no means of making ail their skill available to the sick and the dying; but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness and heartfelt charity. Such service to people is also service to Christ the Lord, who said: "As you did it to one of the least of these my brethren, you did it to me" (*Mt* 25:40).

At the audience granted to the undersigned Prefect, His Holiness Pope John Paul II approved this Declaration, adopted at the ordinary meeting of the Sacred Congregation for the Doctrine of the Faith, and ordered its publication.

Rome, the Sacred Congregation for the Doctrine of the Faith, 5 May 1980.

Franjo Card. Seper
Prefect
Jerome Hamer, *O.P.*
Tit. Archbishop of Lorium
Secretary

Natural Death Statutes and Proposals

Table D1:

Comparison of Existing Natural Death Statutes*

	Ala.	Ark.	Calif.	Del.	D.C.	Id.
Is directivet limited to patients who will die very soon even with treatment?	yes	no	yes	yes	yes	yes
May form of directive be varied?	yes	yes	no	yes	yes	no
May proxy be named in directive?	possibly	possibly	no	yes	possibly	no
May directive be written for a child or an incompetent adult?	no	yes	no	no	no	no
Is directive said to be nullified by pregnancy?	yes	no	yes	yes	no	no
Are penalties specified for physicians who refuse to follow a directive?	no	no	yes	no	yes	no
Does the statute specify that the physician must inform the patient (if competent) of the terminal prognosis before the directive is binding?	no	no	yes	no	yes(2)	yes
Is directive binding only if patient knows of terminal condition?	no	no	yes	no	**(3)**	no
Is a waiting period imposed after patient is informed before directive is binding?	no	no	yes	no	no	no
Must a directive be periodically reaffirmed?	no	no	yes	yes	no	yes
Must terminal conditions be confirmed by consultation and certified in writing?	yes	no(1)	yes	yes	yes	no

for footnotes, see p. 312.

Ks.	Nev.	N.M.	N.C.	Ore.	Tx.	Vt.	Va.(10)	Wash.
yes	uncertain	yes	no	yes	yes	yes	no(11)	yes
yes	no[5]	yes	yes	no	no	yes	yes(12	yes
possibly	no	possibly	possibly	no	no	possibly	possibly	possibly y
no	no	for child	yes(6)	no	no	no	no(13)	no
yes	yes	no	no	no	yes	no	no	yes
ves	no	no	no	yes	yes	no(9)	no	no(9)
no(4)	no	no	no	yes	no[4]	no	no	no[4]
no	no	no	no	yes	(8)	no	no	[15]
no	no	no	no	yes	no	no	no	no
no	no	no	no	yes	no	no	no	no
yes	no	yes	yes[7]	yes(7]	yes	no	yes[14]	yes

* A natural death statute is one that establishes a way for patients while competent to direct that treatment at the end of their lives, if they are not then able to make decisions, shall not include artificial interventions that prolong dying. The individual state statutes are given *infra* at pp. 318-87.

t "Directive" means the written instrument implementing a natural death statute for a particular patient.

(1) Except, a directive may be made by legally appointed guardian on behalf of an incompetent adult.

(2) The physician probably is given an affirmative duty to inform all patients whose directives thereby become binding.

(3) If patient is able to comprehend, then directive is binding only if patient is informed. If patient is unable to comprehend, directive is binding when terminal condition is certified.

(4) Except that the desires of a qualified patient at the time are always governing, and the patient probably must be informed if the desires are to have this force.

(5) Must be "substantially" the form given in the statute.

(6) Procedures are specified for comatose incompetent patients.

(7) Does not specify written certification.

(8) Directive is binding only if patient is "qualified" at the time it is executed. The statute does not state that informing a competent patient is essential to qualifying, but it would be reasonable to interpret the statute as entailing this requirement.

(9) Statute specified that physician has a duty to inform the patient or actively assist in selecting another physician but does not specify penalties for failure to do so.

(10) The Virginia statute was passed by both houses and awaiting the governor's signature as of March 17,1983.

(11) The definition of terminal condition requires that death be imminent, but does not specify whether it must be imminent even with the proposed treatment.

(12) Directive may be made orally if done after diagnosis of terminal condition.

(13) A procedure is given for foregoing life-sustaining procedures on behalf of adult incompetent patients.

(14) Where patient is competent, certification need only be made by the attending physician.

(15) If patient is competent, the statute's requirement that the decision be reaffirmed would seem to entail assuring that the patient knows the terminal prognosis.

Medical Treatment Decision Act* (Model Bill)

*The following Model Bill was drafted at Yale Law School in a Legislative Services Project sponsored by the Society for the Right to Die. The use of * and ** is to indicate alternatives.*

1. Purpose

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the Legislature hereby declares that the laws of the State of _____ shall recognize the right of an adult person to make a written declaration instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

2. Definitions

The following definitions shall govern the construction of this act:

(a) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(b) "Declaration" means a witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of Section 3 of this act.

(c) "Life-sustaining procedure" means any medical procedure or intervention which, when applied to a qualified patient, would serve only to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care.

(d) "Qualified patient" means a patient who has executed a declaration in accordance with this act and who has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom shall be the attending physician.

* From *Handbook of Enacted* ***Laws,*** published by the Society for the Right to Die, 250 West 57th Street, New York, N.Y. 10107. Reprinted by permission.

3. Execution of Declaration

Any adult person may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in **a** terminal condition. The declaration shall be signed by the declarant in the presence of two subscribing witnesses *(who are not) **(nomore than one of whom may be) (a) related to the declarant by blood or marriage, (b) entitled to any portion of the estate of the declarant under any will of declarant or codicil thereto then existing or, at the time of the declaration, by operation of law then existing, (c) a claimant against any portion of the estate of the declarant, or (d) directly financially responsible for the declarant's medical care.

It shall be the responsibility of declarant to provide for notification to his attending physician of the existence of the declaration. An attending physician who is so notified shall make the declaration, or a copy of the declaration, a part of the declarant's medical records.

The declaration shall be substantially in the following form, but in addition may include other specific directions. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State of Residence

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness _____

Witness _____

4. Revocation

A declaration may be revoked at any time by the declarant, without regard to his or her mental state or competency, by any of the following methods:

(a) By being canceled. defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his or her presence and by his or her direction.

(b) By a written revocation of the declarant expressing his or her intent to revoke, signed and dated by the declarant. The attending physician shall record in the patient's medical record the time and date when he or she received notification of the written revocation.

(c) By a verbal expression by the declarant of his or her intent to revoke the declaration. Such revocation shall become effective upon communication to the attending physician by the declarant or by a person who is reasonably believed to be acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date and place of the revocation and the time, date and place, if different, of when he or she received notification of the revocation.

5. Physician's Responsibility: Written Certification

An attending physician who has been notified of the existence of a declaration executed under this act shall, without delay after the diagnosis of a terminal condition of the declarant, take the necessary steps to provide for written certification and confirmation of the declarant's terminal condition, so that declarant may be deemed to be a qualified patient, as defined in Section 1(d) of this act.

An attending physician who fails to comply with this section shall be deemed to have refused to comply with the declaration and shall be liable as specified in Section 7(a).

6. Physician's Responsibility and Immunities

The desires of a qualified patient who is competent shall at all times supersede the effect of the declaration.

If the qualified patient is incompetent at the time of'the decision to withhold or withdraw life-sustaining procedures, a declaration executed in accordance with Section 3 of this act is presumed to be valid. For the purpose of this act, a physician or health care facility may presume in the absence of actual

notice to the contrary that an individual who executed a declaration was of sound mind when it was executed. The fact of an individual's having executed a declaration shall not be considered as an indication of a declarant's mental incompetency. *(Age of itself shall not be a bar to a determination of competency.)

In the absence of actual notice of the revocation of the declaration, none of the following, when acting in accordance with the requirements of this act, shall be subject to civil liability therefrom, unless negligent, or shall be guilty of any criminal act or of unprofessional conduct:

(a) A physician or health facility which causes the withholding or withdrawal of life-sustaining procedures from a qualified patient.

(b) A licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures.

7. Penalties

(a) An attending physician who refuses to comply with the declaration of a qualified patient pursuant to this act shall make the necessary arrangements to effect the transfer of the qualified patient to another physician who will effectuate the declaration of the qualified patient. An attending physician who fails to comply with the declaration of a qualified patient or to make the necessary arrangements to effect the transfer shall be civilly liable.

(b) Any person who willfully conceals, cancels, defaces, obliterates, or damages the declaration of another without such declarant's consent or who falsifies or forges a revocation of the declaration of another shall be civilly liable.

(c) Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 4, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide.

8. General Provisions

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this act.shall not, for any purpose, constitute a suicide.

(b) The making of a declaration pursuant to Section **3** shall not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining

procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or non-profit hospital plan, shall require any person to execute a declaration as a condition for being insured for, or receiving, health care services.

(d) Nothing in this act shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this act are cumulative.

(e) This act shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition.

(f) If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Natural Death Statutes, by State*

Alabama

SS 22-8A-1. Short title.

This chapter shall be known and may be cited as the "Natural Death Act." S

22-8A-2. Legislative intent.

The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the legislature hereby declares that the laws of this state shall recognize the right of an adult person to make a written declaration instructing his or her physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

S 22-8A-3. Definitions.

As used in this chapter, the following terms shall have the following meanings, respectively, unless the context clearly indicates otherwise:

(1) Attending physician. The physician selected by, or assigned to, the pafient who has primary responsibility for the treatment and care of the patient.

(2) Declaration. A witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of section 22-8A-4.

(3) Life-sustaining procedure. Any medical procedure or intervention which, when applied to a qualified patient, would serve only to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not such procedure or intervention is utilized. Life-sustaining procedure shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort or care or to alleviate pain.

(4) Physician. A person licensed to practice medicine and osteopathy in the state of Alabama.

(5) Qualified patient. A patient, who has executed a declaration in accordance with this chapter and who has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally

* Statutes have been edited only where necessary to correct spelling and to standardize printing format.

examined the patient, one of whom shall be the attending physician.

(6) Terminally ill or injured patient. A patient whose death is imminent or whose condition is hopeless unless he or she is artificially supported through the use of life-sustaining procedures.

S **22-8A-4. Written declaration; requirements; form.**

(a) Any adult person may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The declaration made pursuant to this chapter shall be: **(1)** In writing; (2) signed by the person making the declaration, or by another person in the declarant's presence and by the declarant's expressed direction; **(3)** dated; and (4) signed in the presence of two or more witnesses at least 19 years of age neither of whom shall be the person who signed the declaration on behalf of and at the direction of the person making the declaration, related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of in-testate succession of this state or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. The declaration of a qualified patient diagnosed as pregnant by the attending physician shall have no effect during the course of the qualified patient's pregnancy.

(b) It shall be the responsibility of declarant to provide for notification to his or her attending physician of the existence of the declaration. An attending physician who is so notified shall make the declaration, or a copy of the declaration, a part of the declarant's medical records.

(c) The declaration shall be substantially in the following form, but in addition may include other specific directions. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

DECLARATION

Declaration made this _____ day of _____ (Month, year). I, _____, being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining

procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State of Residence

_____

_____

Date _____

The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness _____

Witness _____

Date _____

S 22-8A-5. Revocation of written declaration.

(a) A declaration may be revoked at any time by the declarant by any of the following methods:

(1) By being obliterated, burnt, torn, or otherwise destroyed or defaced in a manner indicating intention to cancel;

(2) By a written revocation of the declaration signed and dated by the declarant or person acting at the direction of the declarant; or

(3) By a verbal expression of the intent to revoke the declaration, in the presence of a witness 19 years of age or older who signs and dates a writing confirming that such expression of intent was made. Any verbal revocation shall become effective upon receipt by the attending physician of the above mentioned writing. The attending physician shall record in the patient's medical record the time, date and place of when he or she received notification of the revocation.

(b) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

S 22-8A-3. Certification and confirmation of terminal condition.

An attending physician who has been notified of the existence of a declaration executed under this chapter, without delay after the diagnosis of a terminal condition of the declarant, shall take the necessary steps to provide for written certification and confirmation of the declarant's terminal condition, so that declarant may be deemed to be a qualified patient under this chapter.

§ 22-8A-7. Competency of declarant; liability of participating physician, facility, etc.

The desires of a qualified patient shall at all times supersede the effect of the declaration.

If the qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures, a declaration executed in accordance with section 22-8A-4 is presumed to be valid. For the purpose of this chapter, a physician or medical care facility may presume in the absence of actual notice to the contrary that an individual who executed a declaration was of sound mind when it was executed. The fact of an individual's having executed a declaration shall not be considered as an indication of a declarant's mental incompetency. Age of itself shall not be a bar to a determination of competency.

No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration made in accordance with this chapter shall, as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct.

S 22-8A-8. Refusal of attending physician to comply with declaration; penalties for willful concealment, etc. of declaration or revocation.

(a) An attending physician who refuses to comply with the declaration of a qualified patient pursuant to this chapter shall not be liable for his refusal, but shall permit the qualified patient to be transferred to another physician.

(b) Any person who willfully conceals, cancels, defaces, obliterates or damages the declaration of another without such declarant's consent or who falsifies or forges a revocation of the declaration of another shall be guilty of a Class A misdemeanor.

(c) Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of the revocation of a declaration, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a Class C felony.

§ 22-8A-9. Withholding or withdrawal of procedures not suicide; execution of declaration not to affect sale, etc. of life insurance nor be condition for receipt of health care services; provisions of chapter cumulative.

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide and shall not constitute assisting suicide.

(b) The making of a declaration pursuant to section **22-8A-4** shall not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, medical care facility, or other health care provider, and no health care service plan, health maintenance organization, insurer issuing disability insurance, self-insured employee welfare benefit plan, nonprofit medical service corporation or mutual nonprofit hospital or hospital service corporation shall require any person to execute a declaration as a condition for being insured for, or receiving, health care services.

(d) Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

(e) This chapter shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition.

§ 22-8A-10. Provisions of chapter not an approval of mercy killing, etc.

Nothing in this chapter shall be construed to condone, authorize or approve mercy killing or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.

Ala. Code SS 22-8A-1 through 22-8A-10 (May 27,1981) (Acts 1981, No. 81-772, SS 1-10).

Arkansas

S 82-3801 Right to die with dignity or to have life prolonged.

Every person shall have the right to die with dignity and to refuse and deny the use or application by any person of artificial, extraordinary, extreme or radical medical and surgical means or procedures calculated to prolong his life. Alternatively, every person shall have the right to request that such extraordinary means be utilized to prolong life to the extent possible.

S 82-3802. Written request.

Any person, with the same formalities as are required by the laws of this State for the execution of a will, may execute a document exercising such right and refusing and denying the use or application by any person of artificial, extraordinary, extreme or radical medical or surgical means or procedures calculated to prolong his life. In the alternative, any person may request in writing that all means be utilized to prolong life.

S 82-3803. Whomay execute written request for another.

If any person is a minor or an adult who is physically or mentally unable to execute or is otherwise incapacitated from executing either document, it may be executed in the same form on his behalf:

(a) By either parent of the minor;

(b) By his spouse;

(c) If his spouse is unwilling or unable to act, by his child aged eighteen [18] or over;

(d) If he has more than one [1] child aged eighteen [18] or over, by a majority of such children;

(e) If he has no spouse or child aged eighteen [18] or over, by either of his parents;

(f) If he has no parent living, by his nearest living relative; or

(g) If he is mentally incompetent, by his legally appointed guardian.

Provided, that a form executed in compliance with this Section must contain a signed statement by two [2] physicians that extraordinary means would have to be utilized to prolong life.

§ 82-3803. No liability for actions in accordance with request.

Any person, hospital or other medical institution which acts or refrains from acting in reliance on and in compliance

with such document shall be immune from liability otherwise arising out of such failure to use or apply artificial, extraordinary, extreme or radical medical or surgical means or procedures calculated to prolong such person's life.

Ark. Stat. Ann. SS 82-3801 through 82-3804 (March 30,1977)
(Acts 1977, No. 879, SS 1-4).

California

S 7185. Citation.

This act shall be known and may be cited as the Natural Death Act.

S 7186. Legislative findings and declarations

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

S 7187. Definitions.

The following definitions shall govern the construction of this chapter.

(a) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(b) "Directive" means a written document voluntarily by the declarant in accordance with the requirements of Section 7188. The directive, or a copy of the directive, shall be made part of the patient's medical records.

(c) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgement of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(d) "Physician" means a physician and surgeon licensed by the Board of Medical Quality Assurance or the Board of Osteopathic Examiners.

(e) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

(f) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.

§ 7188. Directive to physicians.

Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this ———— day of ———— (month, year).

I, . , being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____, M.D., whose address is _____, and whose telephone number is _____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

5. This directive shall have no force or effect five years from the date filled in above.

6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County and State of Residence _____

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness _____

Witness _____

S 188.5. Directive to physicians: Patient in skilled nursing facility.

A directive shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in subdivision (c) of Section **1250** at the time the directive is executed unless one of the two witnesses to the directive is a patient advocate or ombudsman as may be designated by the State Department of Aging for this purpose pursuant to any other applicable provision of law. The patient advocate or ombudsman shall have the same qualifications as a witness under Section 7188.

The intent of this section is to recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decisionmaking role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive.

S 7189. Revocation of directive.

(a) A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

(1) By being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction.

(2) By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time and date when he received notification of the written revocation.

(3) By a verbal expression by the declarant of his intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when he received notification of the revocation.

(b) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

S7189.5. Term of directive.

A directive shall be effective for five years from the date of execution thereof unless sooner revoked in a manner prescribed in Section 7189. Nothing in this chapter shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Section 7188, including reexecution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

S 7190 Immunity from civil or criminal liability.

No physician or health facility which, acting in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health professional, acting under the direction of a physician,

who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician, or licensed health professional acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

S 7191. Duties of physician.

(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with Section 7188, and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the desires of the qualified patient.

(b) If the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision. A failure by a physician to effectuate the directive of a qualified patient pursuant to this division shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements, or fails to take the necessary steps, to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.

(c) If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently reexecuted the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician justify effectuating the directive. No physician, and no licensed health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision.

S 7192. Suicide: Insurance.

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide.

(b) The making of a directive pursuant to Section 7188 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally mpaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving , health care services.

S 7193. Rights ascumulative.

Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

§ 7194. Criminal penalties.

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guility of a misdemeanor. Any person who, except where justified or excused by law, falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 7189, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide as provided in Chapter 1 commencing with Section 187) of Title 8 of Part 1of the Penal Code.

S 7195. Construction of chapter.

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmaive or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.

1976 Cal. Stat., Chapter 1439, Code S Health and Safety, SS 7185 hrough 7195 (Sept. 30,1976).

Delaware

S 2501. Definitions.

(a) 'Artificial means' shall mean manufactured or technical contrivances which may be attached to or integrated into the human body, but which are not normally a part of the human body.

(b) 'Attending physician' shall mean the physician selected by the patient or someone on his behalf, or assigned by a health care facility to the patient, which physician has primary responsibility for the treatment and care of the patient.

(c) 'Declarant' shall mean the person on whose behalf a declaration, in accordance with this chapter, is made.

(d) 'Declaration' shall mean a written statement voluntarily executed by the declarant or his agent directing the withholding or withdrawal of certain medical treatment, even if such treatment is the sole means of sustaining life, during a future state of incompetency.

(e) 'Maintenance medical treatment' shall mean any medical or surgical procedure or intervention which utilizes mechanical or other artifical means to sustain, restore, or supplant a vital function; and which would serve only to artifically prolong the dying process and delay the moment of death where death is imminent, whether or not such procedures are utilized. The words 'maintenance medical treatment' shall not include the administration of medication, nor the performance of any medical procedure necessary to provide comfort care or to alleviate pain.

(f) 'Terminal condition' shall mean any disease, illness, injury or condition sustained by any human being from which there is no reasonable medical expectation of recovery and which, as a medical probability, will result in the death of such human being regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life processes.

S 2502. Right of self-determination.

(a) An individual, legally adult, who is competent and of sound mind, has the right to refuse medical or surgical treatment if such refusal is not contrary to existing public health laws. Such individual has the right to make a written, dated declaration instructing any physician, including without limitation the treating physican, to cease or refrain from medical or surgical treatment during a possible pre-stated future incompetency of such person. The declaration shall take effect whenever the circumstances described in the declaration take place, and the fact they have taken place is confirmed in writing by two physicians.

(b) An adult person by written declaration may appoint an agent who will act on behalf of such appointor if, due to a condition resulting from illness or injury and, in the judgment of the attending physician, the appointor becomes incapable of making a decision in the exercise of the right to accept or refuse medical treatment.

(c) An agent appointed in accordance with this section may accept or refuse medical treatment proposed for the appointor if, in the judgment of the attending physician, the appointor is incapable of making that decision. This authority shall include the right to refuse medical treatment which would extend the appointor's life. An agent authorized to make decisions under this chapter has a duty to act in good faith, and with due regard for the benefit and interests of the appointor.

S **2503. Written declaration.**

(a) Any adult person may execute a declaration directing the withholding or withdrawal of maintenance medical treatment, where the person is in a terminal condition and under such circumstances as may be set forth in the declaration. The declaration made pursuant to this chapter shall be:

(1) in writing;

(2) signed by the person making the declaration, or by another person in the declarant's presence at the declarant's expressed direction;

(3) dated; and

(4) signed in the presence of two or more adult witnesses, as set forth in subsection (bj.

(b) The declaration shall be signed by the declarant in the presence of two subscribing witnesses, neither of whom:

(1) is related to the declarant by blood or marriage;

(2) is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the declaration, is so entitled by operation of law then existing;

(3) has, at the time of the execution of the declaration, a present or inchoate claim against any portion of the estate of the declarant;

(4) has a direct financial responsibility for the declarant's medical care; or

(5) is an employee of the hospital or other health care facility in which the declarant is a patient.

(c) Each witness to the declaration shall verify that he is not prohibited, under subsection (b) of this section, from being a witness under the provision of this chapter.

(d) The declaration of a patient diagnosed as pregnant by the attending physician shall be of no effect during the course of the patient's pregnancy. Where a declaration is lacking any

requirement under this subsection and such defect is later corrected by amendment or codicil, whether formally or informally prepared, such declaration shall be valid *ab initio,* notwithstanding the earlier defect.

S 2504. Revocation.

[a) The desires of a declarant who is competent shall at all times supercede the effect of the declaration. A declarant may revoke his declaration at any time, without regard to his mental state or competency. Any of the following methods is sufficient for revocation:

(1) Destruction, cancellation, obliteration, or mutilation of the declaration with an intent to revoke it. If physical disability has rendered the declarant unable to destroy, cancel, obliterate, or mutilate the declaration, he may direct another individual to do so in his presence;

(2) An oral statement made in the presence of two persons, each eighteen years of age or older, which expresses an intent contrary to that expressed in the declaration;

(3) Either a new declaration, made in the same manner with the same formality as the former declaration, which expresses an intent contrary to that expressed in the prior declaration; or a written revocation signed and dated by the declarant.

(b) There shall be no criminal nor civil liability on the part of any person for failure to act in accordance with a revocation, unless such person has actual or constructive knowledge of the revocation.

(c) If the declarant becomes comatose or is rendered incapable of communicating, the declaration shall remain in effect for the termination of the comatose condition, or until such time as the declarant's condition renders him able to communicate.

S 2505. Health care personnel; legal immunity.

Physicians or nurses who act in reliance on a document executed in accordance with this chapter, where such health care personnel have no actual notice of revocation or contrary indication, by withholding medical procedures from an individual who executed such document shall be presumed to be acting in good faith, and unless negligent shall be immune from civil or criminal liability.

For purposes of this chapter a physician or nurse may presume, in the absence of actual notice to the contrary, that an individual who executed a document under this chapter was of sound mind when it was executed.

S 2506. Safeguard provisions.

(a) Anyone who has good reason to believe that the withdrawal or withholding of a maintenance medical treatment in a particular case:

(1) is contrary to the most recent expressed wishes of a declarant;

(2) is being proposed pursuant to a Declaration that has been falsified, forged, or coerced; or

(3) is being considered without the benefit of a revocation which has been unlawfully concealed, destroyed, altered or cancelled; may petition the Court of Chancery for appointment of a guardian for such declarant.

(b) Upon receipt of a declaration, the hospital or the attending physician shall acknowledge receipt of same, and shall include the declaration as part of the declarant's medical records.

(c) A declaration shall be effective for ten years from the date it was declared or executed, unless sooner revoked in a manner permitted under this chapter. Nothing in this chapter shall be construed to prevent any person from re-executing a Declaration at any time.

(d) The Division of Aging and the Public Guardian shall have oversight over any declaration executed by a resident of a sanatorium, rest home, nursing home, boarding home, or related institution as the same is defined in § 1101, Title of the Delaware Code. Such declaration shall have no force nor effect if the declarant is a resident of a sanatorium, rest home, nursing home, boarding home or related institution at the time the declaration is executed unless one of the witnesses is a person designated as a patient advocate or ombudsman by either the Division of Aging or the Public Guardian. The patient advocate or ombudsman must have the qualifications required of other witnesses under this Chapter.

S 2507. Assumptions and presumptions.

(a) Neither the execution of a declaration under this Chapter nor the fact that maintenance medical treatment is withheld from a patient in accordance therewith shall, for any purpose, constitute a suicide.

(b) The making of a declaration pursuant to this Chapter shall not restrict, inhibit, nor impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed or presumed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of maintenance medical treatment from an insured patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health care provider, nor any health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or non-profit hospital service plan, shall require any person to execute a Declaration as a condition to being

insured, or for receiving health care services, nor shall the signing of a Declaration be a bar.

(d) This chapter shall create no presumption concerning the intentions of an individual, who has not executed a declaration, to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition.

S 2508. Penalties.

(a) Whoever threatens directly or indirectly, coerces, or intimidates any person to execute a declaration directing the withholding or withdrawal of maintenance medical treatment shall be guilty of a misdemeanor and upon conviction shall be fined not less than $500 nor more than $1,000; be imprisoned not less than 30 days nor more than 90 days; or both. The Superior Court shall have jurisdiction over such offenses.

(b) Whoever knowingly conceals, destroys, falsifies or forges a document with intent to create the false impression that another person has directed that maintenance medical treatment be utilized for the prolongation of his life is guilty of a Class C felony.

(c) The Superior Court shall have jurisdiction over all offenses under this Chapter.

§ 2509. Exemption from liability; defense.

(a) No physician or other individual, nor any health care facility which, acting in accordance with the requirement of this Chapter, causes the withholding or withdrawal of life-sustaining procedures from a patient, shall be subject to civil liability therefrom. No physician or other person acting under the direction of a physician who participates in the withholding or withdrawal of a life-sustaining procedure in accordance with the provisions of this Chapter shall be guilty of any criminal act or of unprofessional conduct, other determinations to the contrary notwithstanding.

(b] In any action for malpractice governed by Chapter 68 of Title 18, brought against any attending physician or any health care facility, arising out of the observance of the provisions of this Chapter, it shall be a defense to such action that the attending physician or health care facility acted in accordance with a written declaration meeting all of the procedural requirements of this Chapter.

Section 2. This Act shall be known and may be cited as the Delaware Death with Dignity Act.

Section 3. Nothing in this Act shall be construed to condone, authorize, or approve of mercy killing; be construed to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying; nor be construed to be a method of defining or determining a technical state of death.

Section 4. If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act are declared to be severable.

Del. Code Ann. tit. 16, SS 2501 through 2509 (July 12, 1982).

District of Columbia

S 6-2421. Definitions.

For the purposes of this subchapter, the term:

(1) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(2) "Declaration' means a witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of S 6-2422.

(3) "Life-sustaining procedure' means any medical procedure or intervention, which, when applied to a qualified patient, would serve only to artificially prolong the dying process and where, in the judgment of the attending physician and a second physician, death will occur whether or not such procedure or intervention is utilized. The term "life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

(4) "Physician' means a person authorized to practice medicine in the District of Columbia.

(5) "Qualified patient' means a patient who has executed a declaration in accordance with this subchapter and who has been diagnosed and certified in writing to be afflicted with a terminal condition by 2 physicians who have personally examined the patient, one of whom shall be the attending physician.

(6) "Terminal condition' means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.

§ 6-2422. Declaration — Execution; form.

(a) Any persons 18 years of age or older may execute a declaration directing the withholding or withdrawal of life-sustaining procedures from themselves should they be in a

terminal condition. The declaration made pursuant to this subchapter shall be:

(1) In writing;

(2) Signed by the person making the declaration or by another person in the declarant's presence at the declarant's express direction;

(3) Dated; and

(4) Signed in the presence of 2 or more witnesses at least 18 years of age. In addition, a witness shall not be:

(A) The person who signed the declaration on behalf of and at the direction of the declarant;

(B) Related to the declarant by blood or marriage;

(C) Entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto;

(D) Directly financially responsible for declarant's medical care; or

(E) The attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

(b) It shall be the responsibility of the declarant to provide for notification to his or her attending physician of the existence of the declaration. An attending physician, when presented with the declaration, shall make the declaration or a copy of the declaration a part of the declarant's medical records.

(c) The declaration shall be substantially in the following form, but in addition may include other specific directions not inconsistent with other provisions of this subchapter. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

Declaration

Declaration made this _____ day of _____ (month/year).

I, _____, being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying

process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

Address _____

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least 18 years of age and am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

Witness _____

Witness _____

S 6-2423. Same — Restrictions.

A declaration shall have no effect if the declarant is a patient in an intermediate care or skilled care facility as defined in the Health Care Facilities Regulation, enacted June 14,1974 (Reg. 74-15; 20 DCR 1423) at the time the declaration is executed unless 1 of the 2 witnesses to the directive is a patient advocate or ombudsman. The patient advocate or ombudsman shall have the same qualifications as a witness under S 6-2422.

S 6-2424. Same — Revocation.

(a) A declaration may be revoked at any time only by the declarant or at the express direction of the declarant, without regard to the declarant's mental state by any of the following methods:

(1) By being obliterated, burnt, torn, or otherwise destroyed or defaced by the declarant or by some person in the declarant's presence and at his or her direction;

(2) By a written revocation of the declaration signed and dated by the declarant or person acting at the direction of the declarant. Such revocation shall become effective only upon communication of the revocation to the attending physi-

cian by the declarant or by a person acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time and date when he or she receives notification of the written revocation; or

(3) By a verbal expression of the intent to revoke the declaration, in the presence of a witness 18 years or older who signs and dates a writing confirming that such expression of intent was made. Any verbal revocation shall become effective only upon communication of the revocation to the attending physician by the declarant or by a person acting on behalf of the declarant. The attending physician shall record, in the patient's medical record, the time, date, and place of when he or she receives notification of the revocation.

(b) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

S 6-2425. Physician's duty to confirm terminal condition.

(a) An attending physician who has been notified of the existence of a declaration executed under this subchapter, without delay after the diagnosis of a terminal condition of the declarant, shall take the necessary steps to provide for written certification and confirmation of the declarant's terminal condition, so that the declarant may be deemed to be a qualified patient under this subchapter.

(b) Once written certification and confirmation of the declarant's terminal condition is made a person becomes a qualified patient under this subchapter only if the attending physician verbally or in writing informs the patient of his or her terminal condition and documents such communication in the patient's medical record. If the patient is diagnosed as unable to comprehend verbal or written communications, such patient shall become a qualified patient as defined in S 6-2421, immediately upon written certification and confirmation of his or her terminal condition by the attending physician.

(c) An attending physician who does not comply with this section shall be considered to have committed an act of unprofessional conduct under S 2-1326.

S 6-2426. Competency and intent of declarant.

(a) The desires of a qualified patient shall at all times supersede the effect of the declaration.

(b) If the qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures, a decliircllion executed in accordance with S 6-2422 is presumed to be valid. For the purpose of this subchapter, a physician or health facility may presume in the absence of actual notice to the contrary that an individual who executed a declaration was of sound mind when it was executed. The fact of an

individual's having executed a declaration shall not be considered as an indication of a declarant's mental incompetency.

S 6-2427. Extent of medical liability; transfer of patient; criminal offenses.

(a) No physician, licensed health care professional, health facility, or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualifed patient pursuant to a declaration made in accordance with this subchapter shall, as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct.

(b) An attending physician who cannot comply with the declaration of a qualified patient pursuant to this subchapter shall, in conjunction with the next of kin of the patient or other responsible individual, effect the transfer of the qualified patient to another physician who will honor the declaration of the qualified patient. Transfer under these circumstances shall not constitute abandonment. Failure of an attending physician to effect the transfer of the qualified patient according to this section, in the event he or she cannot comply with the directive, shall constitute unprofessional conduct as defined in S 2-1326.

(c) Any person who willfully conceals, cancels, defaces, obliterates, or damages the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another shall commit an offense, and upon conviction shall be fined an amount not to exceed $5,000 or be imprisoned for a period not to exceed 3 years, or both.

(d) Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of the revocation of a declaration, with the intent to cause a withholding or withdrawal of life-sustaining procedures, contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to be hastened, shall be subject to prosecution for unlawful homicide pursuant to S 22-2401.

S 6-2428 Exclusion of suicide; effect of declaration upon issuance.

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this subchapter shall not, for any purpose, constitute a suicide and shall not constitute the crime of assisting suicide.

(b) The making of a declaration pursuant to S 6-2422 shall not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of

life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health care provider, and no health care service plan, health maintenance organization, insurer issuing disability insurance, self-insured employee welfare benefit plan, nonprofit medical service corporation, or mutual nonprofit hospital service corporation shall require any person to execute a declaration as a condition for being insured for, or receiving, health care services.

S 6-2429. Preservation of existing rights.

(a) Nothing in this subchapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this subchapter are cumulative.

(b) This subchapter shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition.

S 6-2430. Effect of subchapter.

Nothing in this subchapter shall be construed to condone, authorize, or approve mercy-killing or to permit any affirmative or deliberate act or omission to end a human life other than to permit the natural process of dying as provided in this subchapter.

D.C. Code Ann. 16, SS 6-2401 through 6-2430 (February 25,1982).

Idaho

S 39-4501. Short title.

This act shall be known and may be cited as the "Natural Death Act."

§ 39-4502. Statement of policy.

The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their medical care, including the decision to have life sustaining procedures withheld or withdrawn in instances of a terminal condition.

The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The legislature further finds that patients suffering from terminal conditions are sometimes unable to express their desire to withhold or withdraw such artificial life prolongation procedures which provide nothing medically necessary or beneficial to the patient because of the progress of the disease process which renders the patient comatose or unable to communicate with the physician.

In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of this state shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life sustaining procedures when such person is suffering from a terminal condition and unable to instruct his physician regarding such procedures because of the terminal condition.

S 39-4503. Definitions.

The following definitions shall govern the construction of this chapter:

(1)"Attending physician" means the physician licensed by the state board of medicine, selected by, or assigned to, the patient who has primary responsibility [responsibility] for the treatment and care of the patient.

(2) "Terminal condition" means an incurable physical condition caused by disease or illness which reasonable medical judgment determines shortens the lifespan of the patient.

(3) "Qualified patient" means a person of sound mind at least eighteen (18) years of age diagnosed by the attending physician to be afflicted with a terminal condition.

(4) "Artificial life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical means to sustain or supplant a vital function which when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. Artificial life-sustaining procedures shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

S 39-4504. Directive for withholding procedures.

Any qualified patient may execute a directive directing the withholding or withdrawal of artificial life-sustaining procedures when such patient becomes unconscious or unable to communicate with his attending physician because of the progress of the terminal condition resulting in his inability to voluntarily determine whether such procedures should be utilized and if such procedures would serve only to prolong the moment of his death and where his attending physician determines that his death is imminent whether or not such

procedures are utilized. The directive shall be signed by the qualified patient in the presence of two (2) witnesses who shall verify in such directive that they are not related to the qualified patient by blood or marriage, that they would not be entitled to any portion of the estate of the qualified patient upon his demise under any will of the qualified patient or codicil thereto then existing, at the time of the directive, or by operation of law then existing. In addition, the witnesses shall verify that they are not the attending physician, an employee of the attending physician or a health facility in which the qualified patient is a patient or any person who has a claim against any portion of the estate of the qualified patient upon his demise at the time of the execution of the directive. The directive shall be in the following form:

DIRECTIVE TO PHYSICIAN

Directive made this _____ day of _____ (month/year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances below:

1. In the absence of my ability to give directions regarding the use of artificial life-sustaining procedures as a result of the disease process of my terminal condition, it is my intention that such artificial life-sustaining procedures should not be used when they would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent whether or not the artificial life-sustaining procedures are utilized.

2. I have been diagnosed and notified that I have a terminal condition known as _____ by _____ , M.D., whose address is _____ and whose telephone number is _____.

3. This directive shall have no force or effect after five years from the date filled in above.

4. I understand the full impact of this directive and I am emotionally and mentally competent to make this directive.

_____
(Name)
(City, County and State)

_____
Witness

_____
Witness

STATE OF IDAHO
County of Ada

We, _____, and _____, the qualified patient and the witnesses respectively, whose names are

signed to the attached and foregoing instrument, being first duly sworn, do hereby declare to the undersigned authority that the qualified patient signed and executed the directive and that he signed willingly and he executed it as his free and voluntary act for the purposes therein expressed; and that each of the witnesses, in the presence and hearing of the qualified patient signed the directive as witness and that to the best of his knowledge the qualified patient was at the time 18 or more years of age, of sound mind and under no constraint or undue influence. We the undersigned witnesses further declare that we are not related to the qualified patient by blood or marriage; that we are not entitled to any portion of the estate of the qualified patient upon his decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the qualified patient is a patient, and that we are not a person who has a claim against any portion of the estate of the qualified patient upon his decease at the present time.

_____
Qualified Patient

_____
Witness

_____
Witness

SUBSCRIBED, sworn to and acknowledged before me by _____, the qualified patient, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 19_____

_____
Notary Public for the State of Idaho
Residing at Boise, Idaho

(SEAL)

S 39-4505. Revocation.

(1) A directive may be revoked at any time by the qualified patient, without regard to his mental state or competence, by any of the following methods:

(a) By being cancelled, defaced, obliterated or burned, torn or otherwise destroyed by the qualified patient or by some person in his presence and by his direction.

(b) By a written revocation of the qualified patient expressing his intent to revoke, signed by the qualified patient.

(c) By a verbal expression by the qualified patient of his intent to revoke the directive.

(2) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation of a directive

made pursuant to this section unless that person has actual knowledge of the revocation.

§ 39-4506. Expiration of directive.

A directive shall be effective for five (5) years from the date of execution unless sooner revoked in a manner described in section 39-4505, Idaho Code. Nothing in this chapter shall be construed to prevent a qualified patient from reexecuting a directive at any time. If the qualified patient becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the qualified patient's condition renders him able to communicate with the attending physician.

§ 39-4507. Immunity.

No physician or health facility, which, acting in accordance with a directive meeting the requirements of this chapter, causes the withholding or withdrawal of artificial life-sustaining procedures from a qualified patient, shall be subject to civil liability or criminal liability therefrom.

§ 39-4508. General provisions.

(1) This chapter shall have no effect or be in any manner construed to apply to persons not executing a directive pursuant to this chapter nor shall it in any manner affect the rights of any such persons or of others acting for or on behalf of such persons to give or refuse to give consent or withhold consent for any medical care, neither shall this chapter be construed to affect chapter 43, title 39, Idaho Code, in any manner.

(2) The making of a directive pursuant to this chapter shall not restrict, inhibit or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of artificial life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(3) No physician, health facility or other health provider and no health care service plan, insurer issuing disability insurance, self-insured employee, welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

Idaho Code SS 39-4501 through 39-4508 (March **1977).**

Kansas

§ 65-28,101 Withholding or withdrawal of life-sustaining procedures; legislative finding and declaration.

The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the legislature hereby declares that the laws of this state shall recognize the right of an adult person to make a written declaration instructing his or her physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

S 65-28,102 Same; definitions.

As used in this act:

(a) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(b) "Declaration" means a witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of K.S.A. 65-28,103.

(c) "Life-sustaining procedure" means any medical procedure or intervention which, when applied to a qualified patient, would serve only to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not such procedure or intervention is utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

(d) "Physician" means a person licensed to practice medicine and surgery by the state board of healing arts.

(e) "Qualified patient" means a patient who has executed a declaration in accordnce with this act and who has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom shall be the attending physician.

S 65-28,103. Same; declaration authorizing; effect during pregnancy of qualifed patient; duty to notify attending physician; form of declaration; severability of directions.

(a) Any adult person may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The declaration made pursuant to this act shall be: (1) In writing; (2) signed by the person making the declaration, or by another person in the declarant's presence

and by the declarant's expressed direction; **(3)** dated; and (4) signed in the presence of two or more witnesses at least eighteen (18) years of age neither of whom shall be the person who signed the declaration on behalf of and at the direction of the person making the declaration, related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of this state or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. The declaration of a qualified patient diagnosed as pregnant by the attending physician shall have no effect during the course of the qualified patient's pregnancy.

(b) It shall be the responsibility of declarant to provide for notification to his or her attending physician of the existence of the declaration. An attending physician who is so notified shall make the declaration, or a copy of the declaration, a part of the declarant's medical records.

(c) The declaration shall be substantially in the following form, but in addition may include other specific directions. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

DECLARATION

Declaration made this _____ day of _____ (month, year).I,_____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artifically prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State

of Residence _____

The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness _____

Witness _____

§ 65-28,104. Same; revocation of declaration.

(a) A declaration may be revoked at any time by the declarant by any of the following methods:

(1) By being obliterated, burnt, torn, or otherwise destroyed or defaced in a manner indicating intention to cancel;

(2) by a written revocation of the declaration signed and dated by the declarant or person acting at the direction of the declarant; or

(3) by a verbal expression of the intent to revoke the declaration, in the presence of a witness eighteen (18) years of age or older who signs and dates a writing confirming that such expression of intent was made. Any verbal revocation shall become effective upon receipt by the attending physician of the above mentioned writing. The attending physician shall record in the patient's medical record the time, date and place of when he or she received notification of the revocation.

(b) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

S 65-28,105. Same; written certification and confirmation of declarant's terminal condition; effect of failure to comply.

An attending physician who has been notified of the existence of a declaration executed under this act, without delay after the diagnosis of a terminal condition of the declarant, shall take the necessary steps to provide for written certification and confirmation of the declarant's terminal condition, so that declarant may be deemed to be a qualified patient under this act.

An attending physician who fails to comply with this section shall be deemed to have refused to comply with the declaration and shall be subject to subsection (a) of K.S.A. 65-28,107.

§ 65-28,106. Same; desires of qualified patient supersede declaration; presumptions relating to declaration; immunity from civil or criminal liability for persons acting pursuant to declaration.

The desires of a qualified patient shall at all times supersede the effect of the declaration.

If the qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures, a declaration executed in accordance with K.S.A. 65-28,103 is presumed to be valid. For the purpose of this act, a physician or medical care facility may presume in the absence of actual notice to the contrary that an individual who executed a declaration was of sound mind when it was executed. The fact of an individual's having executed a declaration shall not be considered as an indication of a declarant's mental incompetency. Age of itself shall not be a bar to a determination of competency.

No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration made in accordance with this act shall, as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct.

S 6548,107. Same; attending physician's refusal to comply with declaration of qualified patient; transfer of patient; unprofessional conduct; unlawful act.

(a) An attending physician who refuses to comply with the declaration of a qualified patient pursuant to this act shall effect the transfer of the qualified patient to another physician. Failure of an attending physician to comply with the declaration of a qualified patient and to effect the transfer of the qualified patient shall constitute unprofessional conduct as defined in K.S.A. 65-2837.

(b) Any person who willfully conceals, cancels, defaces, obliterates or damages the declaration of another without such declarant's consent or who falsifies or forges a revocation of the declaration of another shall be guilty of a class A misdemeanor.

(c) Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of the revocation of a declaration. with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of

such. act, directly causes life-sustaining procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a class E felony.

S 65-28,108. Same; construction and effect of act.

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this act shall not, for any purpose, constitute a suicide and shall not constitute the crime of assisting suicide as defined by K.S.A. 21-3406.

(b) The making a declaration pursuant to K.S.A. 65-28,103 shall not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, medical care facility, or other health care provider, and no health care service plan, health maintenance organization, insurer issuing disability insurance, self-insured employee welfare benefit plan, nonprofit medical service corporation or mutual nonprofit hospital service corporation shall require any person to execute a declaration as a condition for being insured for, or receiving, health care services.

(d) Nothing in this act shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this act are cumulative.

(e) This act shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition.

S 65-28,109.Same; act not to be construed to condone or approve mercy killing or to permit other than natural process of dying.

Nothing in this act shall be construed to condone, authorize or approve mercy killing or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this act.

Kan. Stat. Ann. §§ 65-28,101 through 65-28,109 (July 1, 1979).

Nevada

S 449.540 Definitions.

As used in NRS 449.540 to 449.680, inclusive, unless the

context otherwise requires, the words and terms defined in NRS 449.550 to 449.590, inclusive, have the meanings ascribed to them in those sections.

S 449.550 "Attending physician" defined.

"Attending physician" means the physician, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient.

S 449.560 "Declaration" defined.

"Declaration" means a written document executed by an adult person directing that when he is in a terminal condition and becomes comatose or is otherwise rendered incapable of communicating with his attending physician, life-sustaining procedures shall not be applied.

S 449.570 "Life-sustaining procedure" defined.

"Life-sustaining procedure" means a medical procedure which utilizes mechanical or other artificial methods to sustain, restore or supplant a vital function. The term does not include medication or procedures necessary to alleviate pain.

S 449.580 "Physician" defined.

"Physician" means any person licensed to practice medicine or osteopathy.

S 449.590 "Terminal condition" defined.

"Terminal condition" means an incurable condition which is such that the application of life-sustaining procedures serves only to postpone the moment of death.

S 449.600 Execution of declaration.

Any adult person may execute a declaration directing that when he is in a terminal condition and becomes comatose or is otherwise rendered incapable of communicating with his attending physician, life-sustaining procedures be withheld or withdrawn from him. The person shall execute the declaration in the same manner in which a will is executed, except that a witness may not be:

1. Related to the declarant by blood or marriage.

2. The attending physician.

3. An employee of the attending physician or of the hospital or other health and care facility in which the declarant is a patient.

4. A person who has a claim against any portion of the estate of the declarant.

S 449.610 Form of declaration; entry and removal of declaration from medical records.

The declaration shall be in substantially the following form:

DIRECTIVE TO PHYSICIANS

Date _____

I, _____, being of sound mind, intentionally and voluntarily declare:

1. If at any time I am in a terminal condition and become comatose or am otherwise rendered incapable of communicating with my attending physician, and my death is imminent because of an incurable disease, illness or injury, I direct that life-sustaining procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. It is my intention that this directive be honored by my family and attending physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of my refusal.

3. If I have been found to be pregnant, and that fact is known to my physician, this directive is void during the course of my pregnancy. I understand the full import of this directive, and I am emotionally and mentally competent to execute it.

Signed _____

City, County and State of Residence

The declarant has been personally known to me and I believe _____ to be of sound mind.

Witness _____

Witness _____

Section 3 of the declaration form should be omitted for male declarants.

The executed declaration, or a copy thereof signed by the declarant and the witnesses, shall be placed in the medical record of the declarant and a notation made of its presence and the date of its execution. A notation of the circumstances and date of removal of a declaration shall be entered in the medical record if the declaration is removed for any reason.

S 449.620 Revocation of declaration; immunity in case of failure to act upon revocation.

(1) A declaration may be revoked at any time by the declarant in the same way in which a will may be revoked, or by a verbal expression of intent to revoke. A verbal revocation is effective upon communication to the attending physician by the declarant or another person communicating it on behalf of the declarant. The attending physician shall record the verbal revocation and the date on which he received it in the medical record of the declarant.

(2) No person is liable in a civil or criminal action for failure to act upon a revocation of a declaration unless the person had actual knowledge of the revocation.

S 449.630 Immunity for withholding or withdrawing life-sustaining procedures.

No hospital or other health and care facility, physician or person working under the direction of a physician who causes the withholding or withdrawal of life-sustaining procedures from a patient in a terminal condition who has a declaration in effect and has become comatose or has otherwise been rendered incapable of communicating with his attending physician is subject to criminal or civil liability or to a charge of unprofessional conduct or malpractice as a result of an action taken in accordance with NRS 449.600 to 449.660, inclusive.

S 449.640 Immunity in case of failure to follow directions of patient.

(1) If a patient in a terminal condition has a declaration in effect and becomes comatose or is otherwise rendered incapable of communicating with his attending physician, the physician shall give weight to the declaration as evidence of the patient's directions regarding the application of life-sustaining procedures, but the attending physician may also consider other factors in determining whether the circumstances warrant following the directions.

(2) No hospital or other health care facility, physician or person working under the direction of a physician is subject to criminal or civil liability for failure to follow the directions of the patient to withhold or withdraw life-sustaining procedures.

S 449.650 Effect of declaration respecting suicide, insurance policies; execution of declaration may not be required as condition for insurance, health care services.

(1) A person does not commit suicide by executing a declaration.

(2) The execution of a declaration does not restrict, inhibit or impair the sale, procurement or issuance of any policy of insurance, nor shall it be deemed to modify any term of an existing policy of insurance. No policy of life insurance is impaired or invalidated in whole or in part by the withholding or withdrawal of life-sustaining procedures from an insured person, regardless of any term of the policy.

(3) No person may require another to execute a declaration as a condition for being insured for or receiving health care services.

S 449.660 Penalties.

(1) Any person who willfully conceals, cancels, defaces, obliterates or damages the declaration of another without the consent of the declarant is guilty of misdemeanor.

(2) Any person who falsifies or forges a document purporting to be the declaration of another, or who willfully conceals or withholds personal knowledge of a revocation, with the

intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant and thereby directly causes life-sustaining procedures to be withheld or withdrawn and death to be hastened is guilty of murder.

§ 449.670 Termination of life.

Nothing in NRS 449.600 to 449.620, inclusive, permits any affirmative or deliberate act or omission which ends life other than to permit the natural process of dying.

S 449.680 Other right or responsibility to withhold or withdraw life-sustaining procedures not limited.

Nothing in NRS 449.610 to 449.660, inclusive, limits the right or responsibility which a person may otherwise have to withhold or withdraw life-sustaining procedures.

§ 449.690 Effect of instrument executed before July 1, 1977.

An instrument executed before July 1, 1977, which clearly expresses the intent of the declarant to direct the withholding or withdrawal of life-sustaining procedures from him when he is in a terminal condition and becomes comatose or is otherwise rendered incapable of communicating with his attending physician shall, if executed in a manner which attests voluntary execution and not subsequently revoked, be given the same effect as a declaration prepared and executed in accordance with NRS 449.540 to 449.680, inclusive.

Nev. Rev. Stat. SS 449.550 through 449.590 (May 6, 1977).

New Mexico

S 24-7-1. Short title.

This act [24-7-1 to 24-7-11 NMSA 1978] may be cited as the "Right to Die Act.".

§ 24-7-2. Definitions.

As used in the Right to Die Act:

(A] "maintenance medical treatment" means medical treatment designed solely to sustain the life processes;

(B) "minor" means a person who has not reached the age of majority;

(C) "physician" means an individual licensed to practice medicine in New Mexico; and

(D) "terminal illness" means an illness that will result in death as defined in Section 12-2-4 NMSA 1978, regardless of the use or discontinuance of maintenance medical treatment.

S 24-7-3. Execution of a document.

(A) An individual of sound mind and having reached the age of majority may execute a document directing that if he is ever certified under the Right to Die Act as suffering from a

terminal illness then maintenance medical treatment shall not be utilized for the prolongation of his life.

(B) A document described in Subsection A of this section is not valid unless it has been executed with the same formalities as required of a valid will pursuant to the provisions of the Probate Code [45-1-101 to 45-7-401 NMSA 1978].

S 24-7-4. Execution of a document for the benefit of a terminally ill minor.

(A) If a minor has been certified under the Right to Die Act as suffering a terminal illness, the following individual may execute the document on his behalf:

(1) the spouse, if he has reached the age of majority; or

(2) if there is no spouse, or if the spouse is not available at the time of the certification or is otherwise unable to act, then either the parent or guardian of the minor.

(B) An individual named in Subsection A of this section may not execute a document:

(1) if he has actual notice of contrary indications by the minor who is terminally ill; or

(2) when executing as a parent or guardian, if he has actual notice of opposition by either another parent or guardian or a spouse who has attained the age of majority.

(C) A document described in Subsection A of this section is not valid unless it has been executed with the same formalities as required of a valid will under the Probate Code, and has been certified upon its face by a district court judge pursuant to Subsection D of this section.

(D) Any person executing a document pursuant to the provisions of this section shall petition the district court for the county in which the minor is domiciled, or the county in which the minor is being maintained, for certification upon the face of the document. The court shall appoint a guardian ad litem to represent the minor and may hold an evidentiary hearing before certification. All costs shall be charged to the petitioner. If the district court judge is satisfied that all requirements of the Right to Die Act have been satisfied, that the document was executed in good faith and that the certification of the terminal illness was in good faith, then he shall certify the document.

S 24-7-5. Certification of a terminal illness.

(A) For purposes of the Right to Die Act, certification of a terminal illness may be rendered only in writing by two physicians, one of whom is the physician in charge of the individual who is terminally ill. A copy of any such certification shall be kept in the records of the medical facility where the patient is being maintained. If the patient is not being maintained in a medical facility, a copy shall be retained by the physician in charge in his own case records.

(B) A physician who certifies a terminal illness under this section is presumed to be acting in good faith. Unless it is alleged and proved that his action violated the standard of reasonable professional care and judgment under the circumstances, he is immune from civil or criminal liability that otherwise might be incurred.

§ 24-7-6. Revocation of a document.

(A) An individual who has executed a document under the Right to Die Act may, at any time thereafter, revoke the document. Revocation may be accomplished by destroying the document, or by contrary indication expressed in the presence of one witness who has reached the age of majority.

(B) A minor may revoke the document in the manner provided under Subsection A of this section. During the remainder of his terminal illness, any such revocation may constitute actual notice of his contrary indication.

§ 24-7-7. Physician's immunity from liability.

(A) After certification of a terminal illness under the Right to Die Act, a physician who relies on a document executed under that act, of which he has no actual notice of revocation or contrary indication, and who withholds maintenance medical treatment from the terminally ill individual who executed the document, is presumed to be acting in good faith. Unless it is alleged and proved that the physician's actions violated the standard of reasonable professional care and judgment under the circumstances, he is immune from civil or criminal liability that otherwise might be incurred.

(B) A physician who relies on a document executed on behalf of a terminally ill minor under the Right to Die Act and certified on its face by a district court judge pursuant to Section 4 of that act, and who withholds maintenance medical treatment from the terminally ill minor on whose behalf the document was executed, is presumed to be acting in good faith, if he has no actual notice of revocation or contrary indication. Unless it is alleged and proved that the physician's actions violated the standard of reasonable professional care and judgment under the circumstances, he is immune from civil or criminal liability that otherwise might be incurred.

(C) In the absence of actual notice to the contrary, a physician may presume that an individual who executed a document under the Right to Die Act was of sound mind when the document was executed.

(D) Any hospital or medical institution or its employees which act or refrain from acting in reasonable reliance on and in compliance with a document executed under the Right to Die Act shall be immune from civil or criminal liability that otherwise might be incurred.

§ 24-7-8. Insurance.

(A) The withholding of maintenance medical treatment from any individual pursuant to the provisions of the Right to Die Act shall not, for any purpose, constitute a suicide.

(B) The execution of a document pursuant to the Right to Die Act shall not restrict, inhibit or impair in any manner the sale, procurement or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding of maintenance medical treatment under the Right to Die Act from an insured individual, notwithstanding any term of the policy to the contrary.

(C) No physician, health facility or other health care provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan or nonprofit hospital service plan shall require any person to execute a document pursuant to the Right to Die Act as a condition for being insured for, or receiving, health care service.

S 24-7-9. Cumulative provisions.

Nothing in the Right to Die Act shall impair or supersede any existing legal right or legal responsibility which any person may have to effect the withholding or nonutilization of any maintenance medical treatment in any lawful manner. In such respect the provisions of the Right to Die Act are cumulative.

S 24-7-10. Penalties.

(A) Whoever knowingly and willfully conceals, destroys, falsifies or forges a document with intent to create the false impression that another person has directed that no maintenance medical treatment be utilized for the prolongation of his life or the life of a minor, or whoever knowingly and willfully conceals evidence of revocation of a document executed pursuant to the Right to Die Act, is guilty of a second degree felony, punishable by imprisonment in the penitentiary for a period of not less than ten years nor more than fifty years or a fine of not more than ten thousand dollars ($10,000) or both.

(B) Whoever knowingly and willfully conceals, destroys, falsifies or forges a document with intent to create the false impression that another person has not directed that maintenance medical treatment not be utilized for the prolongation of his life is guilty of a third degree felony, punishable by imprisonment in the penitentiary for a term of not less than two years nor more than ten years or a fine of not more than five thousand dollars ($5,000) or both.

(C) Whoever executes a document under the Right to Die Act for the benefit of a terminally ill minor and who either has actual notice of contrary indications by the minor who is terminally ill, or, when executing as a parent or guardian, has actual notice of opposition by either another parent or guard-

ian or a spouse, is guilty of a second degree felony, punishable by imprisonment in the penitentiary for a period of not less than ten years nor more than fifty years, or by a fine of not more than ten thousand dollars ($10,000) or both.

§ 24-7-11. Application.

The Right to Die Act applies to all persons executing documents in conformity with that act on or after the effective date of the Right to Die Act.

N.M. Stat. Ann. §§ 24-7-1 through 24-7-10 (April 7, 1977).

North Carolina

§ 90-320. General purpose of article.

(a) The General Assembly hereby recognizes that an individual's rights as a citizen of this State include the right to a peaceful and natural death. This Article is to establish a procedure for the exercise of that right and to state expressly the extent of a physician's obligation to preserve the life of his patient in situations where artificial means may be used to sustain the circulatory and respiratory functions for an indefinite period.

(b) Nothing in this Article shall be construed to authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying. Nothing in this Article shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this Article are cumulative.

§ 90-321. Right to a natural death.

(a) As used in this Article the term:

(1) "Declarant" means a person who has signed a declaration in accordance with subsection (c);

(2) "Extraordinary means" is defined as any medical procedure or intervention which in the judgment of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function;

(3) "Physician" means any person licensed to practice medicine under Article 1 of Chapter 90 of the laws of the State of North Carolina.

(b) If a person has declared, in accordance with subsection (c) below, a desire that his life not be prolonged by extraordinary means; and the declaration has not been revoked in accordance with subsection (e); and (1) It is deter-

mined by the attending physician that the declarant's present condition is

a. Terminal; and

b. Incurable; and

(2) There is confirmation of the declarant's present condition as set out above in subdivision (b)(1) by a physician other than the attending physician; then extraordinary means may be withheld or discontinued upon the direction and under the supervision of the attending physician.

(c) The attending physician may rely upon a signed, witnessed, dated and proved declaration:

(1) Which expresses a desire of the declarant that no extraordinary means be used to prolong his life if his condition is determined to be terminal and incurable; and

(2) Which states that the declarant is aware that the declaration authorizes a physician to withhold or discontinue the extraordinary means; and

(3) Which has been signed by the declarant in the presence of two witnesses who believe the declarant to be of sound mind and who state that they (i) are not related within the third degree to the declarant or to the declarant's spouse, (ii) do not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon his death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it then provides, (iii) are not the attending physician, or an employee of the attending physician, or an employee of a health facility in which the declarant is a patient, or an employee of a nursing home or any group-care home in which the declarant resides, and (iv) do not have a claim against any portion of the estate of the declarant at the time of the declaration; and

(4) Which has been proved before a clerk or assistant clerk of superior court, or a notary public who certifies substantially as set out in subsection (d) below.

(d) The following form is specifically determined to meet the requirements above:

"Declaration of **A** Desire For A Natural Death

"I, _____, being of sound mind, desire that my life not be prolonged by extraordinary means if my condition is determined to be terminal and incurable. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means.

"This the _____ day of _____

Signature _____

"I hereby state that the declarant, _____, being of sound mind signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would be entitled to any portion of the estate of the declarant, under any existing will or codicil of the declarant, or as an heir under the Intestate Succession Act if the declarant died on this date without a will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

Witness _____

Witness _____

The clerk or the assistant clerk, or a notary public may, upon proper proof, certify the declaration as follows:

"Certificate

"I, _____, Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for _____ County hereby certify that _____, the declarant, appeared before me and swore to me and to the witnesses in my presence that this instrument is his Declaration Of A Desire For A Natural Death, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes expressed in it.

"I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____ declarant, sign the attached declaration, believing him to be of sound mind; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provides at that time, and (iii) they were not a physician attending the declarant or an employee of an attending physician or an employee of a health facility in which the declarant was a patient or an employee of a nursing home or any group-care home in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration. This the _____ of _____

Clerk (Assistant Clerk) of Superior Court
or Notary Public '(circle one as appropriate)
for the County of

The above declaration may be proved by the clerk or the assistant clerk, or a notary public in the following manner:

(1) Upon the testimony of the two witnesses; or

(2) If the testimony of only one witness is available, then

a. Upon the testimony of such witness, and

b. Upon proof of the handwriting of the witness who is dead or whose testimony is otherwise unavailable, and

c. Upon proof of the handwriting of the declarant, unless he signed by his mark; or upon proof of such other circumstances as will satisfy the clerk or assistant clerk of the superior court, or a notary public as to the genuineness and due execution of the declaration.

(3) If the testimony of none of the witnesses is available, such declaration may be proved by the clerk or assistant clerk, or a notary public

a. Upon proof of the handwriting of the two witnesses who testimony is unavailable, and

b. Upon compliance with paragraph c of subdivision (2) above.

Due execution may be established, where the evidence required above is unavoidably lacking or inadequate, by testimony of other competent witnesses as to the requisite facts.

The testimony of a witness is unavailable within the meaning of this subsection when the witness is dead, out of the State, not to be found within the State, insane or otherwise incompetent, physically unable to testify or refuses to testify.

If the testimony of one or both of the witnesses is not available the clerk or the assistant clerk, or a notary public of superior court may, upon proper proof, certify the declaration as follows:

"Certificate

"I _____, Clerk (Assistant Clerk) of Court for the Superior Court or Notary Public (circle one as appropriate) of _____ County hereby certify that based upon the evidence before me I am satisfied as to the genuineness and due execution of the attached declaration by _____, declarant, and that the declarant's signature was witnessed by

_____, and _____, who at the time of the declaration met the qualifications of G.S. 90-321(c)(3).

"This the _____ day of _____

Clerk (Assistant Clerk) of Superior Court
or Notary Public (circle one as appropriate)
for — County."

(e) The above declaration may be revoked by the declarant, in any manner by which he is able to communicate his intent to revoke, without regard to his mental or physical condition. Such revocation shall become effective only upon communication to the attending physician by the declarant or by an individual acting on behalf of the declarant.

(f) The execution and consummation of declarations made in accordance with subsection (c) shall not constitute suicide for any purpose.

(g) No person shall be required to sign a declaration in accordance with subsection (c) as a condition for becoming insured under any insurance contractor for receiving any medical treatment.

(h) The withholding or discontinuance of extraordinary means in accordance with this section shall not be considered the cause of death for any civil or criminal purposes nor shall it be considered unprofessional conduct. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense.

(i) Any certificate in the form provided by this section prior to July 1, 1979 shall continue to be valid.

S 90-322. Procedures for natural death in the absence of a declaration.

(a) If a person is comatose and there is no reasonable possibility that he will return to a cognitive sapient state or is mentally incapacitated, and:

(1) It is determined by the attending physician that the person's present condition is:

a. Terminal; and

b. Incurable; and

c. Irreversible; and

(2) There is confirmation of the person's present condition as set out above in this subsection, by a majority of a committee of three physicians other than the attending physician; and

(3) A vital function of the person could be restored by extraordinary means or a vital function of the person is being sustained by extraordinary means;

then, extraordinary means may be withheld or discontinued in accordance with subsection (b).

(b) If a person's condition has been determined to meet the conditions set forth in subsection (a) and no instrument has been executed as provided in G.S. 90-321 the extraordinary means to prolong life may be withheld or discontinued upon the direction and under the supervision of the attending physician at the request (i) of the person's spouse, or (ii) of a guardian of the person, or (iii) of a majority of the relatives of the first degree, in that order. If none of the above are available then at the discretion of the attending physician the extraordinary means may be discontinued upon the direction and under the supervision of the attending physician.

(c) Repealed by Session Laws 1979, c. 715, s. 2.

(d) The withholding or discontinuance of such extraordinary means shall not be considered the cause of death for any civil or criminal purpose nor shall it be considered unprofessional conduct. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense.

N.C. Gen. Stat. SS 90-320 through 90-322 (July1,1977).

Oregon

S 97.050 Definitions for ORS 97.050 to 97.090.

As used in ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990:

(1) "Attending physician" means the physician with primary responsibility for the care and treatment of a patient.

(2) "Directive" means a written document voluntarily executed by a declarant in accordance with the requirements set forth in ORS 97.055.

(3) "Life-sustaining procedure" means any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore or supplant a vital function of a qualified patient that is used to maintain the life of a person suffering from a terminal condition and serves only to artificially prolong the moment of death and when death is imminent whether or not such procedures are used. 'Life-sustaining procedure' does not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(4) "Physician" means an individual licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(5) "Qualified patient" means an individual, 18 years of age or older, whom the attending physician and one other physician, upon diagnostic examination of the patient, certify to be suffering from a terminal condition.

(6) "Terminal condition" means an incurable condition caused by injury, disease or illness which, regardless of the application of life-sustaining procedures would within reasonable medical judgment produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.

S 97.055 Execution of directive; form; witness qualifications and responsibility; revocation of directive.

(1) An individual of sound mind and 18 years of age or older may at any time execute or reexecute a directive directing the withholding or withdrawal of life-sustaining procedures should the declarant become a qualified patient. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____ (month, year). I _____, being of sound mind, wilfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians, one of whom is the attending physician, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____, M.D., whose address is _____, and whose telephone number is _____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

4. This directive shall have no force or effect five years from the date filled in above.

5. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County and State of Residence _____

I hereby witness this directive and attest that:

(1) I personally know the Declarant and believe the Declarant to be of sound mind.

(2) To the best of my knowledge, at the time of the execution of this directive, I:

(a) Am not related to the Declarant by blood or marriage,

(b) Do not have any claim on the estate of the Declarant,

(c) Am not entitled to any portion of the Declarant's estate by any will or by operation of law, and

(d) Am not a physician attending the Declarant or a person employed by a physician attending the Declarant.

(3) I understand that if I have not witnessed this directive in good faith I may be responsible for any damages that arise out of giving this directive its intended effect.

Witness _____

Witness _____

(2) A directive made pursuant to subsection (1) of this section is only valid if signed by the declarant in the presence of two attesting witnesses who, at the time the directive is executed, are not:

(a) Related to the declarant by blood or marriage; or

(b) Entitled to any portion of the estate of the declarant upon his decease under any will or codicil of the declarant or by operation of law at the time of the execution of the directive; or

(c) The attending. physician or an employee of the attending physician or of a health facility in which the declarant is a patient; or

(d) Persons who at the time of the execution of the directive have a claim against any portion of the estate of the declarant upon the declarant's decease.

(3) One of the witnesses, if the declarant is a patient in a house for the aged licensed under ORS chapter 442 at the time the directive is executed, shall be an individual designated by the Department of Human Resources for the purpose of

determining that the declarant is not so insulated from the voluntary decision-making role that the declarant is not capable of wilfully and voluntarily executing a directive.

(4) A witness who does not attest a directive in good faith shall be liable for any damages that arise from giving effect to an invalid directive.

(5) A directive made pursuant to ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 may be revoked at any time by the declarant without regard to his mental state or competency by any of the following methods:

(a) By being burned, torn, canceled, obliterated or otherwise destroyed by the declarant or by some person in his presence and by his direction.

(b] By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant.

(c) By a verbal expression by the declarant of his intent to revoke the directive.

(6) Unless revoked, a directive shall be effective for five years from the date of execution. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him able to communicate with the attending physician.

S 97.060 Validity of directive as to physician.

A directive that is valid on its face is valid as to any physician for the purposes of ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 unless the physician has actual knowledge of facts that render the directive invalid or is under the direction of a court not to give effect to the directive.

S 97.065 Effect of directive.

(1) It shall be lawful for an attending physician or a licensed health professional under the direction of an attending physician, acting in good faith and in accordance with the requirements of ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990, to withhold or withdraw life-sustaining procedures from a qualified patient who has properly executed a directive in accordance with the requirements of ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990.

(2) A physician or licensed health professional or health facility under the direction of a physician who, acting in good faith and in accordance with the requirements of ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990, causes the withholding or withdrawal of life-sustaining procedures shall not be guilty of any criminal offense, shall not be subject to civil

liability and shall not be in violation of any professional oath, affirmation or standard of care.

(3) A physician or licensed health professional or health facility shall not be guilty of any criminal offense, shall not be subject to civil liability and shall not be in violation of any professional oath, affirmation or standard of care for failing to assume the duties created by or for failing to give effect to any directive or revocation made pursuant to ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 unless that physician has actual knowledge of the directive or revocation.

S 97.070 Duties created by directive.

(1) Except as provided in this section, no physician, licensed health professional or medical facility shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the withdrawal or withholding of life-sustaining procedures.

(2) (a) An attending physician shall make a directive or a copy of a directive made pursuant to ORS 97.050 to 97.090 and subsections **(5)** to (7) of 97.990 part of the patient's medical record.

(3) A physician or medical facility electing for any reason not to participate in the withholding or withdrawal of life-sustaining procedures in accord with a directive made pursuant to ORS 97.050 to 97.090 and subsections **(5)** and (7) of 97.990 shall:

(a) Make a reasonable effort to locate a physician or medical facility that will give effect to a qualified patient's directive and shall have a duty to transfer the qualified patient to that physician or facility; or

(b) At the request of a patient or of the patient's family, a physician or medical facility shall transfer the patient to another physician or medical facility that will reconsider circumstances which might make ORS 97.050 to 97.090 and subsections **(5)** to (7) of 97.990 applicable to the patient.

S 97.075 Procedure prior to withdrawal of life-sustaining procedures.

(1) Before withdrawing or withholding life-sustaining procedures from a qualified patient who is mentally competent in the opinion of the attending physician, the attending physician shall determine that the directive is valid under the requirements of ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 and shall determine that all steps proposed to be taken are in accord with the desires of the qualified patient.

(2) Before withdrawing or withholding life-sustaining procedures from a qualified patient who is not mentally competent in the opinion of the attending physician, the attending physician shall determine that the directive is valid under the requirements of ORS 97.050 to 97.090 and subsections (5) to (7)

of 97.990 and shall weigh the directive with other surrounding circumstances such as information from the affected family or the nature of the patient's illness, injury or disease to determine if the steps proposed to be taken are, in the opinion of the attending physician, in accord with the known desires of the qualified patient. If the declarant was a qualified patient at least **14** days before executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be in accord with the desires of the qualified patient for the purposes of this subsection.

S 97.080 Effect of directive on insurance.

(1) Except as provided in subsection **(2)** of this section, the making of a directive pursuant to ORS **97.050** to **97.090** and subsections **(5)** to **(7)** of **97.990** shall not restrict, inhibit or impair in any manner the sale, procurement or issuance of any policy of insurance, nor shall it be deemed to modify the terms of an existing policy of insurance.

(2) No physician, health facility, health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, nonprofit hospital service plan or other direct or indirect health service provider shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

(3) No policy of insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient.

§ 97.085 Construction of ORS 97.050 to 97.090 concerning mercy killing, exclusiveness and suicide.

(1) Nothing in ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 shall be construed to condone, authorize or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990.

(2) Nothing in ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 are cumulative.

(3) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of ORS 97.050 to 97.090 and subsections (5) to (7) of 97.990 shall not, for any purpose, constitute a suicide.

S 97.090 Prohibited acts.

(1) No person shall by willfully concealing or destroying a revocation or by willfully falsifying or forging a directive cause the withdrawal or withholding of life-sustaining procedures.

(2) No person shall by willfully concealing or destroying a directive or by willfully falsifying or forging a revocation cause an individual's intent with respect to the withholding or withdrawal of life-sustaining procedures not to be given effect.

Or. Rev. Stat. SS 97.050 through 97.090 (June 9,1977).

Texas

S 1. Short title.

This Act shall be known and may be cited as the Natural Death Act.

S 2. Definitions.

In this Act:

(1) "Attending physician" means the physician selected oy, or assigned by the physician selected by, the patient who has primary responsibility for the treatment and care of the patient.

(2) "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of Section **3** of this Act. The directive, or a copy of the directive, shall be made part of the patient's medical records.

(3) "Life-sustaining procedure" means a medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, noted in the qualified patient's medical records, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(4) "Physician" means a physician and surgeon licensed by the Texas State Board of Medical Examiners.

(5) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, and the other shall be chosen by the patient or the attending physician, who have each personally examined the patient.

(6) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death of the patient

S 3. Directive for withholding or withdrawal of life-sustaining procedures in event of terminal condition.

Any adult person may execute a directive for the withholding or withdrawal of life-sustaining procedures in the event of a terminal condition. The directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant on his decease under any will of the declarant or codicil thereto or by operation of law. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, a patient in a health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. The signature of the declarant shall be acknowledged, and the witnesses shall subscribe and swear to the directive before a notary public. The directive shall be in the following form:

"DIRECTIVE TO PHYSICIANS

"Directive made this _____ day of _____ (month, year).

"I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

"1. If at any time I should have an incurable condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

"2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

"3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

"4. I have been diagnosed and notified as having a terminal condition by _____, M.D., whose address is _____ and whose telephone number is _____. I understand that if I have not filled in the physician's name and

address, it shall be presumed that I did not have a terminal condition when I made out this directive.

"5. This directive shall be in effect until it is revoked.

"6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

"7. I understand that I may revoke this directive at any time.

"Signed _____

City, County, and State of Residence _____

The declarant has been personally known to me and I believe him or her to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate on his decease, nor am I the attending physician of declarant or an employee of the attending physician or a health facility in which declarant is **a** patient, or a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease.

"Witness _____

"Witness _____

"STATE OF TEXAS

COUNTY OF _____

"Before me, the undersigned authority, on this day personally appeared _____, and _____, known to me to be the declarant and witnesses whose names are subscribed to the foregoing instrument in their respective capacities, and, all of said persons being by me duly sworn, the declarant, _____, declared to me and to the said witnesses in my presence that said instrument is his Directive to Physicians, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes therein expressed.

"Declarant _____

"Witness _____

"Witness _____

"Subscribed and acknowledged before me by the said Declarant, _____, and by the said witnesses, _____ and _____, on this _____ day of _____, 19_____

_____

Notary Public in and for

_____

County, Texas"

SS 4. Revocation of directive.

(a) A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

1. by being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction;

2. by a written revocation of the declarant expressing his intent to revoke, signed and dated bv the declarant. Such revocation shall become effective only on communication to an attending physician by the declarant or by a person acting on behalf of the declarant or by mailing said revocation to an attending physician. An attending physician or his designee shall record in the patient's medical record the time and date when he received notification of the written revocation and shall enter the word "VOID" on each page of the copy of the directive in the patient's medical records; or

3. by a verbal expression by the declarant of his intent to revoke the directive. Such revocation shall become effective only on communication to an attending physician by the declarant or by a person acting on behalf of the declarant. An attending physician or his designee shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when he received notification of the revocation and shall enter the word "VOID" on each page of the copy of the directive in the patient's medical records.

(b) Except as otherwise provided in this Act, there shall be no criminal or civil liability on the part of any person for failure to act on a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

S 5. Duration of directive.

A directive shall be effective until it is revoked in a manner prescribed in Section 4 of this Act. Nothing in this Act shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of Section 3 of this Act, including reexecution subsequent to a diagnosis of a terminal condition. If the declarant has executed more than one directive, such time shall be determined from the date of execution of the last directive known to the attending physician. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders him or her able to communicate with the attending physician.

S 6. Civil or criminal liability.

No physician or health facility which, acting in accordance with the requirements of this Act, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom unless negligent. No health professional, acting under the direction of a physician, who participates in the withholding or withdrawal

of life-sustaining procedures in accordance with the provisions of this Act shall be subject to any civil liability unless negligent. No physician, or health professional acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this Act shall be guilty of any criminal act or of unprofessional conduct unless negligent. No physician, health care facility, or health care professional shall be liable either civilly or criminally for failure to act pursuant to the declarant's directive where such physician, health care facility, or health care professional had no knowledge of such directive.

S 7. Failure to execute directive.

'(a) Prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with the form of the directive set out in Section 3 of this Act, and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the existing desires of the qualified patient and are communicated to the patient.

(b) If the declarant was a qualfied patient prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no health professional acting under the direction of a physician, shall be criminally or civillv liable for failing to effectuate the directive of the qualified patient pursuant to this subsection. A failure by a physician to effectuate the directive of a qualified patient pursuant to this subsection may constitute unprofessional conduct if the physician refuses to make the necessary arrangements or fails to take the necessary steps to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.

(c) If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently reexecuted the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician justifies effectuating the directive. No physician, and no health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection.

§ 8. Effect on offense of aiding suicide and insurance policies.

(a) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this Act shall not, for any purpose, constitute an offense under Section 22.08, Penal Code.

(b) The making of a directive pursuant to Section 3 of this Act shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health provider, and no health care service plan, or insurer issuing insurance, may require any person to execute a directive as a condition for being insured for, or receiving, health care services nor may the execution or failure to execute a directive be considered in any way in establishing the premiums for insurance.

§ 9. Tampering with directive.

A person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guilty of a Class A misdemeanor. A person who falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 4 of this Act, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for criminal homicide under the provisions of the Penal Code.

§ 10. Mercy killing not condoned.

Nothing in this Act shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this Act.

§ 11. Act as cumulative.

Nothing in this Act shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this Act are cumulative.

Tex. Rev. Civ. Stat. Ann. art. 4590h (August 29,1977).

Vermont

SS 1.18 V.S.A. Chapter 111 is added to read:

S 5251 Purpose and policy.

The state of Vermont recognizes that a person as a matter of right may rationally make an election as to the extent of medical treatment he will receive in the event that his physical state reaches such a point of deterioration that he is in a terminal state and there is no reasonable expectation that life can be continued with dignity and without pain. A person has a fundamental right to determine whether or not life sustaining procedures which would cause prolongation of life beyond natural limits, should be used or withdrawn.

S 5252. Definitions.

The following definitions shall be applicable in the construction of this chapter:

(1) "Attending physician" means the physician selected by, or assigned to the patient, who has primary responsibility for the treatment and care of the patient.

(2) "Extraordinary measures" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which, in the judgment of the attending physician, when applied to the patient, would serve only to artificially postpone the moment of death and where, in the judgment of the attending physician, the patient is in a terminal state.

(3) "Terminal care document" means a document which, when duly executed, contains the express direction that no extraordinary measures be taken when the person executing said document is in a terminal state, without hope of recovery from such state and is unable to actively participate in the decision-making process.

(4) "Physician" means a medical doctor licensed to practice in the state of Vermont.

(5) "Terminal state" means an incurable condition causd by injury, disease or illness which regardless of the application of life-saving procedures would, within reasonable medical judgment, produce death and where application of life-sustaining procedures would only postpone the moment of death.

S 5253. Terminal care document.

A person of sound mind who is 18 years of age or older may execute at any time a document commonly known as a terminal care document, directing that no extraordinary measures be used to prolong his life when he is in a terminal state. The document shall only be effective in the event that the person is incapable of participating in decisions about his care and may, but need not, be in form and substance substantially as follows:

"To my family, my physician, my lawyer, my clergyman. To any medical facility in whose care I happen to be. To any individual who may become responsible for my health, welfare or affairs.

"Death is as much a reality as birth, growth, maturity and old age—it is the one certainty of life. If the time comes when I, _____, can no longer take part in decisions of my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

"If the situation should arise in which I am in a terminal state and there is no reasonable expectation of my recovery, I direct that I be allowed to die a natural death and that my life not be prolonged by extraordinary measures. I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.

"This statement is made after careful consideration and is in accordance with my strong convictions and beliefs. I want the wishes and directions here expressed carried out to the extent permitted by law. Insofar as they are not legally enforceable, I hope that those to whom this will is addressed will regard themselves as morally bound by these provisions.

Signed: _____

Date: _____

Witness: _____

Witness: _____

Copies of this request have been given to:"

_____

_____

_____

S 5254. Execution and witnesses.

The document set forth in section **5253** shall be executed by the person making the same in the presence of two or more subscribing witnesses, none of whom shall be the person's spouse, heir, attending physician or person acting under the direction or control of the attending physician or any other person who has at the time of the witnessing thereof any claims against the estate of the person.

S 5256. Action by physician.

An attending physician and any other physician under his direction or control, having in his possession his patient's terminal care document, or having knowledge that such a duly executed document is part of the patient's record in the institution in which he is receiving care, shall be bound to follow as closely as possible the dictates of said document. However, if because of moral conflict with the spirit of this act, a physician finds it impossible to follow his patient's directions, he shall forthwith have a duty to so inform his patient or

actively assist in selecting another physician who is willing to honor the patient's directions, or both.

S 5257. Revocation.

A person who has validly executed a document consistent with the provisions of sections **5253** and **5254** may revoke the same orally in the presence of two or more witnesses, at least one of whom shall not be a spouse or a relative as specified in 15 V.S.A. SS 1 or **2,** or by burning, tearing or obliterating the same or by causing the same to be done by some other person at his direction and in his presence. A terminal care document may be revoked only as provided herein.

S 5258. Duty to deliver.

Any person having in his possession a ,duly executed terminal care document, if it becomes known to him that the person executing the same is in such circumstances that the terms of the terminal care document might become applicable, shall forthwith deliver the same to the physician attending the person executing said document or to the hospital in which said person is a patient.

S 5259. Immunity.

An attending physician, other physician, nurse, health professional or any other person acting for him or under his control, or hospital within which the person may be, shall forever be immune from any civil or criminal liability for any act or intentional failure to act if said act or intentional failure to act is done pursuant to the terminal care document.

S 5260. Suicide.

The withholding or withdrawal of life-sustaining procedures from a patient who has executed a document consistent with the purposes of section **5253** shall at no time be construed as a suicide for any legal purpose.

S 5261. Freedom from influence.

No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee, welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a terminal care document as a condition for being insured for, or receiving, health care services; nor can health care or services be refused except as is hereinbefore provided because a person is known to have executed a terminal care document.

§ 5262. Presumptions.

This chapter shall not be construed to create a presumption that in the absence of a terminal care document, a person wants extraordinary measures to be taken.

S 2.13 V.S.A.S1801 is amended to read:

S 1801. Forgery and counterfeiting of papers, documents, etc.

A person who wittingly, falsely and deceitfully makes, alters, forges or counterfeits, or wittingly, falsely or deceitfully causes to be made, altered, forged or counterfeited, or procures, aids or counsels the making, altering, forging or counterfeiting, of a writ, process, public record, or any certificate, return or attestation of a clerk of a court, public register, notary public, justice or other public officer, in relation to a matter wherein such certificate, return or attestation may be received as legal proof, or a charter, deed, or any evidence or muniment of title to property, will, terminal care document, testament, bond, or writing obligatory, letter of attorney, policy of insurance, bill of lading, bill of exchange, promissory note, or an order drawn on a person or corporation, or on a state, county or town or school district treasurer, for money or other property, or an acquittance or discharge for money or other property, or an acceptance of a bill of exchange, or endorsement or assignment of a bill of exchange or promissory note, for the payment of money, or any accountable receipt for money, goods or other property, or certificate of stock, with intent to injure or defraud a person, shall be imprisoned not more than ten years and fined not more than $1,000.00.

§ 3. Effective date.

This act shall take effect from passage.

Vt. Stat. Ann. tit. 18, §§ 5251 through 5262 and tit. 13, § 1801 (April 8, 1982).

Virginia

§ 54-325.8:1. Policy statement; short title.

The General Assembly finds that all competent adults have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, withheld or withdrawn.

The General Assembly further finds that the artificial prolongation of life for persons with a terminal condition may cause loss of individual dignity and secure only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the patient.

In order that the dignity, privacy and sanctity of persons with such conditions may be respected even after they are no longer able to participate actively in decisions concerning themselves, the General Assembly hereby declares that the laws of the Commonwealth of Virginia shall recognize the right of a competent adult to make an oral or written declaration instructing his physician to withhold or withdraw life-prolong-

ing procedures or to designate another to make the treatment decision for him, in the event such person is diagnosed as suffering from a terminal condition.

The provisions of this article shall be known and may be cited as the "Natural Death Act of Virginia."

S 54-325.8:2. Definitions.

As used in this Act:

"Attending physician" means the primary physician who has responsibility for the treatment and care of the patient.

"Declaration" means (i) a witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of S 54-325.8:3 or (ii) a witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as suffering from a terminal condition and in accordance with the provisions of S 54-325.8:3.

"Life-prolonging procedure" means any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

"Physician" means a person licensed to practice medicine in the Commonwealth of Virginia.

"Qualified patient" means a patient who has (i) made a declaration in accordance with this Act and (ii) been diagnosed and certified in writing by the attending physician, (and, in any case where the patient is comatose, incompetent or otherwise physically or mentally incapable of communication, by one other physician who has examined the patient] to be afflicted with a terminal condition.

"Terminal condition" means a condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty, (i) there can be no recovery and (ii) death is imminent.

"Witness" means a person who is not a spouse or blood relative of the patient.

S 54-325.8:3. Procedure for making a declaration; notice to physician.

Any competent adult may, at any time, make a written declaration directing the withholding or withdrawal of life-prolonging procedures in the event such person should have a terminal condition. A written declaration shall be signed by the declarant in the presence of two subscribing witnesses. An

oral declaration may be made by a competent adult in the presence of a physician and two witnesses by any nonwritten means of communication at any time subsequent to the diagnosis of a terminal condition.

It shall be the responsibility of the declarant to provide for notification to his attending physician that a declaration has been made. In the event the declarant is comatose, incompetent or otherwise mentally or physically incapable, any other person may notify the physician of the existence of a declaration. An attending physician who is so notified shall promptly make the declaration or a copy of the declaration, if written, a part of the declarant's medical records. If the declaration is oral, the physician shall likewise promtly make the fact of such declaration a part of the patient's medical record.

S 54-325.8:4. Suggested form of written declaration.

A declaration executed pursuant to this Act may, but need not, be in the following form, and may include other specific directions including, but not limited to, a designation of another person to make the treatment decision for the declarant should he be (i) diagnosed as suffering from a terminal condition and (ii) comatose, incompetent or otherwise mentally or physically incapable of communication. Should any other specific directions be held to be invalid, such invalidity shall not affect the declaration.

Declaration made this _____ day of _____ (month/year), _____ willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

_____

(Signed)

The declarant is known to me and I believe him or her to be of sound mind.

Witness

Witness

§ 54-325.8:5. Revocation of declaration.

A declaration may be revoked at any time by the declarant (i) by a signed, dated writing; or (ii] by physical cancellation or destruction of the declaration by the declarant or another in his presence and at his direction; or (iii) by an oral expression of intent to revoke. Any such revocation shall be effective when comunicated to the attending physician. No civil or criminal liability shall be imposed upon any person for a failure to act upon a revocation unless that person has actual knowledge of such revocation.

§ 54-325.8:6. Procedure in absence of declaration; no presumption.

Nothing in this Act shall be construed in any manner to prevent the withholding or the withdrawal of life-prolonging procedures from an adult patient with a terminal condition who (i) is comatose, incompetent or otherwise physically or mentally incapable of communication and (ii) has not made a declaration in accordance with this Act, provided there is consultation and agreement for the withholding or the withdrawal of life-prolonging procedures between the attending physician and any of the following individuals, in the following order of priority if no individual in a prior class is reasonably available, willing and competent to act:

1. The judicially appointed guardian or committee of the person of the patient if one has been appointed. This paragraph shall not be construed to require such appointment in order that a treatment decision can be made under this section;

2. The person or persons designated by the patient in writing to make the treatment decision for him should he be diagnosed as suffering from a terminal condition; or

3. The patient's spouse; or

4. An adult child of the patient or, it the patient has more than one adult child, by a majority of the children who are reasonably available for consultation; or

5. The parents of the patient; or

6. The nearest living relative of the patient.

In any case where the treatment decision is made by a person specified in paragraph 3, 4, 5, or 6, there shall be at least two witnesses present at the time of the consultation when the treatment decision is made.

The absence of a declaration by an adult patient shall not give rise to any presumption as to his intent to consent to or refuse life-prolonging procedures.

S 54-325.8:7. Transfer of patient.

An attending physician who refuses to comply with the declaration of a qualified patient or the treatment decision of a person designated to make the decision (i) by the declarant in his declaration or (ii) pursuant to S **58-325.8:6** shall make a reasonable effort to transfer the patient to another physician.

§ 54-325.8:8. Immunity from liability; burden of proof; presumption.

A health care facility, physician or other person acting under the direction of a physician shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of the withholding or the withdrawal of life-prolonging procedures from a patient with a terminal condition in accordance with this Act. A person who authorizes the withholding or withdrawal of life-prolonging procedures from a patient with a terminal condition in accordance with a qualified patient's declaration or as provided in S 54-325.8:6 shall not be subject to criminal prosecution or civil liability for such action.

The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-prolonging procedures did not, in good faith, comply with the provisions of this Act. A declaration made in accordance with this Act shall be presumed to have been made voluntarily.

S 54-325.8:9. Willful destruction, concealment, etc. of declaration or revocation; penalties.

Any person who willfully conceals, cancels, defaces, obliterates, or damages the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another, thereby causing life-prolonging procedures to be utilized in contravention of the previously expressed intent of the patient shall be guilty of a Class **6** felony.

Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of the revocation of a declaration, with the intent to cause a withholding or withdrawal of life-prolonging procedures, contrary to the wishes of the declarant, and thereby, because of such act, directly causes life-prolonging procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a Class **2** felony.

S 54-325.8:10. Mercy killing or euthanasia prohibited.

Nothing in this Act shall be construed to condone, authorize or approve mercy killing or euthanasia, or to permit

any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

S 54-325.8:11. Effect of declaration; suicide; insurance; declarations executed prior to effective date.

The withholding or withdrawal of life-prolonging procedures from a qualified patient in accordance with the provisions of this Act shall not, for any purpose, constitute a suicide. Nor shall the making of a declaration pursuant to this Act effect the sale, procurement or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally imparied or invalidated by the withholding or withdrawal of life-prolonging procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary. A person shall not be required to make a declaration as a condition for being insured for, or receiving, health care services.

The declaration of any qualified patient made prior to the effective date of this Act shall be given effect as provided in this Act.

S 54-325.8:12. Preservation of existing rights.

The provisions of this Act are cumulative with existing law regarding an individual's right to consent or refuse to consent to medical treatment and shall not impair any existing rights or responsibilities which a health care provider, a patient, including a minor or incompetent patient, or a patient's family may have in regard to the withholding or withdrawal of life-prolonging medical procedures under the common law or statutes of the Commonwealth.

S 54-325.8:13. Severability.

If any provision of this Act is held invalid, such invalidity shall not affect other provisions of the Act which can be given effect without the invalid provision. To this end, the provisions of this Act are severable.

Passed by the Virginia Assembly Feb. 1983, awaiting Governor's signature as of March 17,1983.

Washington

§ 70.122.010. Legislative findings.

The legislature finds that adult persons have the fundamental right to control the decisons relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The legislature further finds that, in the interes of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sutaining procedures in the event of a terminal condition.

S 70.122.020 Definitions.

Unless the context clearly requires otherwise, the definitions contained in this section shall apply throughout this chapter.

(1) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(2) "Directive" means a written document voluntarily executed by the declarer in accordance with the requirements of RCW 70.122.030.

(3) "Health facility" means a hospital as defined in RCW 70.38.020(7) or a nursing home as defined in RCW 70.38.020(8).

(4) "Life-sustaining procedure" means any medical or surgical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(5) "Physician" means a person licensed under chapters 18.71 or 18.57 RCW.

(6) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians one of whom shall be the attending physician, who have personally examined the patient.

(7) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.

(8) "Adult person" means a person attaining the age of majority as defined in RCW 26.28.010 and 26.28.015.

§ 70.122.030 Directive to withhold or withdraw life-sustaining procedures.

(1) Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the delcarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the directive. The directive, or a copy thereof, shall be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded to the health facility upon the withdrawal of life-sustaining procedures. The directive shall be essentially in the following form, but in addition may include other specific directions:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____ (month, year]. I _____, being of sound mind, wilfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s)as the final expression of my legal right to refuse

medical or surgical treatment and I accept the consequences from such refusal.

(c) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(d) 1 understanding the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County, and State of Residence _____

The declarer has been personally known to me and I believe him or her to be of sound mind.

Witness _____

Witness _____

(2) Prior to effectuating a directive the diagnosis of a terminal condition by two physicians shall be verified in writing, attached to the directive, and made a permanent part of the patient's medical records.

S 70.122.040 Revocation of directive.

(1) A directive may be revoked at any time by the declarer, without regard to declarer's mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in declarer's presence and by declarer's direction.

(b) By a written revocation of the declarer expressing declarer's intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.

(c) By a verbal expression by the declarer of declarer's intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

(2) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

(3) If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose

condition or until such time as the declarer's condition renders declarer able to communicate with the attending physician.

S 70.122.050 Liability of health personnel, facilities.

No physician or health facility which, acting in good faith in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health personnel, acting under the direction of a physician, who participates in good faith in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician, or licensed health personnel acting under the direction of a physician, who participates in good faith in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

S 70.122.060 Procedures by physician.

(1) Prior to effectuating a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall make a reasonable effort to determine that the directive complies with RCW 70.122.030 and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are currently in accord with the desires of the qualified patient.

(2) The directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no licensed health personnel acting in good faith under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection. If the physician refuses to effectuate the directive, such physician shall make a good faith effort to transfer the qualified patient to another physician who will effectuate the directive of the qualified patient.

S 70.122.070 Effects of carrying out directive — insurance.

(1) The withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the patient's directive in accordance with the provisions of this chapter shall not, for any purpose, consitute a suicide.

(2) The making of a directive pursuant to RCW 70.122.030 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured

qualified patient, notwithstanding any term of the policy to the contrary.

(3) No physician, health facility,.or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

S 70.122.080 Effects of carrying out directive on cause of death.

The act of withholding or withdrawing life-sustaining procedures when done pursuant to a directive described in RCW 70.122.030 and which causes the death of the declarer, shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of any person that placed the declarer in a terminal condition and the death of the declarer.

S 70.122.090 Criminal conduct — penalties.

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarer's consent shall be guilty of a gross misdemeanor. Any person who falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in RCW 70.122.040 with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarer, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for murder in the first degree as defined in RCW 9A.32.030.

S 70.122.100 Mercy killing not authorized.

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

§ 70.122.900 Short title.

This act shall be known and may be cited as the "Natural Death Act."

S 70.122.905 Severability.

If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application, and to this end the provisions of this act are severable.

Wash. Rev. Code Ann. SS 70.122.010 through 70.122.905 (June 7, 1979).